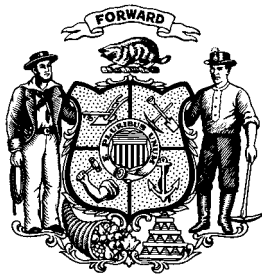


# **Wisconsin Public Health Emergency Plan (PHEP)**

**Version 3.0**  
**Revised 1-20-2005**



**State of Wisconsin**  
Department of Health and Family Services  
**DIVISION OF PUBLIC HEALTH**

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## **PART A**

### **ADMINISTRATION**

#### **Section 1: Introduction**

- A. The purpose of the Public Health Emergency Plan (PHEP) is to enable participating institutions and agencies to meet local, regional and state needs in a collaborative and organized manner in the event of bioterrorism, other infectious disease outbreaks and other public health threats and emergencies (BOIDDOOPHTE) and chemical, biological, radiological, nuclear, explosive (CBRNE) incidents that may involve large numbers of affected individuals by:
1. Utilizing the National Incident Management System (NIMS) to insure that state, local and tribal agencies have a standardize approach to prepare, prevent, respond to, and recover from an incident.
  2. Identifying the necessary structure to allow the participants to call upon outside resources.
  3. Describing the process for activating the PHEP, operational parameters during the incident between participants and field operations, termination of the incident, recovery from the incident, and evaluation of performance.
  4. Making provisions for the protection of health care providers, emergency responders, and residents in the incident of a natural or unnatural outbreak of an infectious disease.
  5. Providing authority and powers for local public health departments to request interstate mutual aid through Wisconsin Act 186.
- B. The Public Health Emergency Plan is developed collaboratively with the State of Wisconsin Hospital Emergency Preparedness Plan (WHEPP). Additionally, the PHEP is to be developed as a supporting plan to the State of Wisconsin Emergency Operations Plan, Annex H, "Health and Medical," of the respective County Emergency Operations Plans.

**Section 2: Membership**

- A. Per Statute 252.03, health officers have the authority to take all measures necessary to prevent, suppress, and control infectious disease in their jurisdictions.
- B. Because a public health emergency can quickly deplete the resources of a local public health department (LPHD), Wisconsin LPHDs have established PHEP regions.
- C. LPHDs and Tribal Health Centers have self-selected into 12 consortia and have signed Memorandums of Understanding for membership.
- D. The 12 consortia enhance preparedness through planning and coordination with affiliate (non-contractual) members of their consortia such as, hospitals, county emergency management offices, EMS, fire departments, lab, hazmat teams, law enforcement, human services, volunteer organizations, etc.

**Section 3: Public Health Emergency Plan (PHEP)**

- A. PHEP is used to coordinate regional resources to respond to a BOIDDOOPHTE or CBRNE incident. A qualified disaster for PHEP is an incident which overwhelms the resources and staff of a participant institution(s) and requires mutual aid with other participant institutions and/or community, regional, state or national resources. The qualified disaster may be defined in terms of varying levels of severity.
  - 1. Level 1 – the participant institution(s) in the affected community can care for all the patients/victims or monitor all the exposed individuals/contacts.
  - 2. Level 2 – the participant institution(s) in the affected community require community resources to care for patients/victims or monitor all the exposed individuals/contacts.
  - 3. Level 3 – the participant institution(s) in the community may require the support of other participant institutions in one or more neighboring regions or those of a neighboring state.
  - 4. Level 4 – the participant institution(s) in the community require the support of other participant institutions within the region and the state. National/Federal resources are required to successfully manage the incident.
- B. There are likely to be two types of qualifying disasters:
  - 1. Fast Breaking Incident - This type of disaster develops rapidly and produces a large number of casualties in a very short period of time.
  - 2. Slow Developing Incident - This type of disaster develops gradually over time and may produce a large number of casualties over a sustained period of time. The use of biological agents or the outbreaks of infectious diseases may cause this type of disaster.
- C. **DHFS**
  - 1. DHFS is notified for a Level 1-4 Fast Breaking or Slow Developing incident.
  - 2. DHFS assumes that local personnel, including first responders, emergency government officials, medical providers and health department staff, are the first points of contact after an incident occurs or emerges.
  - 3. DHFS will provide technical advice, consultation, coordination and on-site assistance as requested or required for protecting the public's health and safety for all levels of disaster.
  - 4. DHFS will implement the PHEP in an incident.
  - 5. In implementing PHEP, the participant institutions agree to comply with applicable federal and state laws (such as COBRA, EMTALA, and HIPPA) unless otherwise suspended per statute.



**Section 4: Post Incident Evaluation**

- A. As per established protocols, the Emergency Management directors for the affected counties involved in the incident will organize a meeting for the purpose of conducting an overall After Action Report of the incident.
- B. If the Emergency Operating Center (EOC) is not activated, all partners involved, including the chairs of the Hospital Regional Teams and representatives from LPHDs for the affected regions, will organize a meeting for the purpose of conducting an overall evaluation of the incident under PHEP.
- C. Such a meeting and evaluation should be conducted in a timely manner (two-three weeks) so that maximum benefit is derived and information is not lost due to the passage of time. For purposes of PHEP, such an evaluation session should identify:
  - 1. The course of incidents at the participant institutions and any associated support providers it activated;
  - 2. Problems encountered during the incident related to PHEP;
  - 3. The strengths/weaknesses of PHEP and opportunities for improvement identified as a result of the incident;
  - 4. Any other information which may be useful.
- D. The results of these evaluations should be communicated to DHFS and posted on the Wisconsin Health Alert Network.

**Section 5: Public Health Emergency Plan (PHEP) Approval**

- A. PHEP shall be routinely reviewed and modified annually in November once exercises testing the PHEP are complete. A PHEP Review Committee consisting of LPHD and Division of Public Health representatives shall be established with input from Emergency Management to accept recommendations for PHEP improvement and editing.
- B. PHEP is subject to modification or improvement under the following situations: following an exercise and post incident evaluation, as an outcome of the evaluation process at any time or, if deemed appropriate, such modification or improvement may be deferred to the next annual review process.
- C. A virtual parking lot is posted on the HAN for consortia staff to generate PHEP related issues that will be addressed annually in November.
- D. A midyear process check will be conducted in June/July to review the list of issues generated in the virtual parking lot that will be addressed during the annual review in November.
- E. After Version 3.0, modifications to the PHEP will be tracked electronically in the document.
- F. Copies of the revised PHEP are to be distributed to all LPHDs and Tribes.

## **PART B**

### **OPERATIONS**

#### **Section 6: Notification of an Incident**

- A. Purpose: To define the various aspects of notification and communication between participant organizations during a CBRNE incident or other infectious disease outbreak.
- B. Scope: Describes notification during a fast breaking and slow developing CBRNE or infectious disease incident categories. Notification levels are identified. Guidance on which organizations are expected to notify other organizations is provided.
- C. Concept of Operations:

##### **1. LPHD**

###### **a. Fast Breaking Incident**

In the event of such a disaster, notification of the incident will come from credible sources such as the Incident Commander, hospitals, EMS, fire, State Public Health, 911, law enforcement, other participant institutions and state or regional agencies, depending on the scope of the disaster.

- 1) Level 1: The LPHD and hospital or EOC, if activated, is notified by the responding agency of an incident.
- 2) Level 2, 3, or 4: The LPHD determines or is notified by the responding EMS service, 911, hospital or the Incident Commander that the incident is likely to exceed local capabilities. Area LPHDs are to activate PHEP. The Incident Commander is to notify Emergency Management of the disaster and the need to activate the local EOC.
- 3) Internal LPHD Damage: Area LPHD(s) suffering internal damage will notify the 911 Center and EMS or the Incident Commander that it is unable to provide essential services. This information is to be communicated to the local EOC as soon as possible.

###### **b. Slow Developing Incident**

*Delayed* refers to incidents where the precipitating incident is unknown until the appearance of syndromes or disease cases. The LPHDs along with area hospitals and clinics will monitor the situation.

- 1) Healthcare facilities are to notify the LPHD immediately if they are suspicious of or identify the following:
  - a) Diseases listed as Category 1 on the back of the Acute and Infectious Disease reporting form (see Resource 1). That includes the Centers for Disease Control and Prevention (CDC) A, B, C

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diseases which may indicate use of a biological agent or an outbreak of the infectious diseases (see Resource 2).

- 2) The LPHDs are to follow locally established protocols as well as the protocols outlined in Section 4 - Infection Control Measures of the Wisconsin Hospital Bioterrorism Preparedness Plan. (See Resource 3, DHFS EpiNet Wisconsin Disease Surveillance Manual.)
- 3) The LPHD in collaboration with the State Division of Public Health will confirm their findings.
- 4) If the situation involves the CDC Category A, B, C, disease or an outbreak of infectious disease, the LPHDs will communicate with the State Division of Public Health. It is the State Division of Public Health's responsibility to communicate this information to all health care facilities in the State.
- 5) The LPHDs are to coordinate with County Emergency Management on the need to activate the local EOCs.
- 6) After deciding to activate the local EOC, federal, state and county response agencies and law enforcement are to be notified.

### 2. DHFS

#### a. Fast Breaking Incident

In the event of such a disaster, notification of the State Department of Health and Family Services will likely come from the following sources: LPHD(s), 911 dispatch centers, health care providers, state or county emergency management, media, and state or regional agencies, depending on the scope of the disaster.

- 1) For local or Level 1 incidents, DHFS should be notified.
- 2) For a larger or Level 2-4 incident, DHFS should be notified immediately.
- 3) DHFS assistance includes:
  - a. Surveillance
  - b. Investigation
  - c. Emergency lab services
  - d. State coordination of activities
  - e. On-site assistance
  - f. Notification network (Health Alert Network – HAN) for other agencies and affected parties
- 4) The incoming call is routed to the appropriate staff person or the 24/7 on-call staff which covers four major areas:
  - a. Natural disaster or chemical spill

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- b. Communicable disease
  - c. Nuclear/Radiological
  - d. Human services
- 5) A decision is made on whom to contact and next steps. The immediate list of contacts includes LPHDs, regional and central DHFS staff and the Wisconsin Emergency Management duty officer, if appropriate.
  - 6) The degree of the incident will determine the type and scale of the response.
3. **DHFS notification to Potential Affected Agencies**
- a. **Fast Breaking Incident**

If the DHFS is alerted to some incident in advance or is one of the first agencies to be notified of an incident, it has the capability to notify the majority of parties that would be affected. (See Attach 1, 24/7 Emergency Notification System.)

    - 1) DHFS will alert regional DPH offices, LPHDs, State Lab of Hygiene, hospital emergency departments and Wisconsin Emergency Management (WEM) through the Health Alert Network.
    - 2) County Emergency Management may directly contact law enforcement and the dispatch center for contacts to fire departments and EMS services.
    - 3) Wisconsin Emergency Management is also able to activate the Department of Justice TIME system which has a direct link to all dispatch centers in the state.
    - 4) DHFS and WEM will consult with LPHD and County Emergency Management to determine who needs to be notified and how notification will occur.
    - 5) DPH and WEM will consult with LPHD and County Emergency Management on the need to activate the local, regional or state PHEP and state and local EOCs.
    - 6) Depending on the type and severity of the incident, DHFS will notify the CDC and WEM who will then inform the FEMA Region V Emergency Operations Center (ROC) of incidents taking place in Wisconsin.
  - b. **Slow Developing Incident**

In a slow developing incident where the precipitating incident is unknown until the appearance of syndromes or disease cases, the LPHD(s) along with the hospital(s) and clinic(s) and the DHFS will monitor the situation. The notification process summarized above for fast breaking incidents can be applied in whole or in part for a slower developing biological incident.

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- 1) Once health care facilities or laboratories identify any of the CDC Category A, B, C diseases, which may indicate use of a biological agent or outbreaks of other infectious diseases, they are to notify DHFS, LPHDs and health care facilities immediately according to the protocols outlined in Section 8: Active Surveillance.
- 2) The State Division of Public Health in collaboration with the LPHD, labs, hospitals and clinics will confirm their findings.
- 3) If the situation involves a CDC Category A, B, C disease or an outbreak of infectious disease, the state and LPHDs will communicate that information to all health care facilities.
- 4) The state and LPHDs will consult with state and on the need to activate the state and local EOCs.
- 5) After deciding to activate state and local EOCs, state and local response agencies and hospitals will be notified.
- 6) The State EOC will inform the FEMA Region V Emergency Operations Center (ROC) of incidents taking place in Wisconsin.

**Section 7: Public Health Emergency Plan (PHEP) Activation**

- A. Purpose: Define the activation of the PHEP and supporting locals plans.
- B. Scope: Address circumstances under which the PHEP will be activated.
- C. Concept of Operations:
  - 1. Upon notification of a potential public health incident, the local health officer (or designee) in the affected community will determine activation of the local PHEP. This will include sending representatives to the local EOC (if activated by the local emergency management director) to participate in coordinating the health and medical aspects of the response utilizing the Incident Command System.
  - 2. If other counties in the surrounding area activate their EOCs, they are to notify their LPHDs and tribal health centers that will then determine the need to activate their PHEPs.
  - 3. All local health officers (and tribal health directors or designee, when appropriate) in the area that have activated their PHEPs will be responsible for:
    - a. Implementing their PHEP as needed.
    - b. Ensuring that LPHD representatives are sent to their local EOC.
    - c. Compliance with NIMS standardized incident command structure.
    - d. Notifying the local EOC with an estimate of the staff they have available and the actions they are taking.
    - e. The safety of LPHD personnel.
  - 4. Each activated EOC in the area will communicate information regarding LPHD staffing and resource capabilities to the EOC(s) of the affected county or counties.
  - 5. Upon notification of a potential public health incident, the state health officer (or designee) will determine activation of their PHEP. This will include sending representatives to the state EOC (if activated by the state emergency management director) to participate in coordinating the health and medical aspects of the response utilizing the Incident Command System.

## **Section 8: Active Surveillance**

- A. Purpose: To identify and quantify communicable diseases and health-related incidents, particularly those which may be caused by or associated with bioterrorism, other infectious disease outbreaks and other public health threats and emergencies.
- B. Scope: Surveillance is the ongoing, systematic collection, analysis, interpretation and dissemination of data regarding a health-related incident for use in public health action to reduce morbidity and mortality and to improve health. Passive surveillance enables a baseline of disease incidence to be created for all reportable conditions and some seasonal conditions such as influenza-like illness. Active surveillance is initiated when the number, type or characteristics of illnesses or incidents is measurably different from this baseline **or** when there is suspicion that a particular illness or incident may be present but undetected by routine surveillance. Active surveillance is initiated using a case definition developed in collaboration with the investigating health department, DPH and CDC as needed, together with questionnaires, instructions for sampling and shipping, treatment recommendations, travel histories and contact tracing information as appropriate.
- C. Concept of Operations:
  - 1. **LPHD**
    - a. Maintain passive surveillance with the complete and timely reporting of reportable and unusual conditions, as specified on the DHFS form 4151, in Wisconsin statute chapter 252.05 and administrative rule chapter HFS 145.
    - b. Provide contact tracing and case follow-up per DPH guidelines.
    - c. Initiate active surveillance if conditions require it, and notify the DHFS and all clinicians within the health department jurisdiction of the associated case definition and other documents as needed.
    - d. Report all cases and progress in contact tracing to the DHFS in a timely fashion.
    - e. Develop a PHEP for communication between clinicians (human and animal) and health officers.
  - 2. **DHFS**
    - a. Routinely and emergently analyze incoming case reports for possible outbreaks or epidemics, and provide timely reports back to clinicians (human and animal) and health departments.
    - b. Routinely and emergently consult with federal and other state agencies as needed in order to coordinate disease investigations with regional or federal investigations.
    - c. Routinely and emergently provide to clinicians (human and animal) and health departments current statewide epidemiologic information on any disease outbreak, case definitions and supplemental documentation,



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consultation, and coordination of surveillance activities if multiple local jurisdictions or state agencies are involved.

- d. Through the Regional Offices, make available appropriate staff to assist LPHDs as needed in emergency situations.

### D. Related Documents:

Resource 1: 4151 Report Forms

**Section 9: Mutual Aid**

- A. Purpose: Wisconsin Act 186 provides the authority for local health departments to request mutual aid in a situation that warrants an increased capacity due to over-extension or loss of resources.
- B. Scope: Under the law, upon the request of a county, city, village, town or person acting under an incident command system (ICS), the personnel of any emergency management program, EMS program, fire department or local health department may assist the requester within the requester's jurisdiction without regard to any other jurisdictional provision.

C. Concept of Operations:

1. Activation of Mutual Aid

The authority and powers for local public health departments to request interstate mutual aid lie within Wisconsin Act 186 (Attach 2).

a. Mutual Aid Agreement shall be activated in the event of:

- 1) A declaration of a state of disaster by a participating government, Governor or President of the United States,
- 2) The finding of a state of emergency by the local health officer of the governing body of the participating agency,
- 3) Local health resources have become strained or depleted and require immediate assistance.

2. Request for Mutual Aid

In the event of any of the above listed conditions, the recipient of the mutual aid shall:

a. Pre-Emergency Operation Center Activation

- 1) Make the request directly to the Provider via telephone or other means from whom the aid is sought and follow up via faxing the entire Attachment X.
- 2) A copy of the entire Attachment X shall be simultaneously submitted to the State Emergency Operations Center (SEOC) via fax.
- 3) The Provider from whom the mutual aid is requested shall furnish mutual aid to cope with the public health emergency to the Recipient, subject to the conditions listed below.
- 4) The Provider shall make a good-faith effort to notify the Recipient of any available mutual aid within a reasonable amount of time of the received Attachment X and follow up via return fax to the Recipient and the SEOC.

b. Post-Emergency Operations Center Activation

- 1) In the event that a Local or County Emergency Operations Center has been activated, all requests for Mutual Aid and/or resources shall be

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made by the Recipient through the governing Emergency Operations Center.

### 3. Conditions

- a. The Attachment X submitted by the Recipient shall specify at the minimum:
  - 1) the amount and type of resources being requested
  - 2) the location to which the resources are to be dispatched
  - 3) the specific time by which such resources are needed
- b. The Provider shall take such action as is necessary to provide and make available the resources requested given that the Provider, in its sole discretion, shall determine what resources are available to furnish the requested aid.

### 4. Supervision and Control

The personnel, equipment and resources of any Provider shall fall under operational control of the Recipient. Direct supervision and control of dedicated resources shall remain with the Provider as they carry out the instructions of the Recipient. Recipient may be operating under the Incident Command System structure.

### 5. Termination and/or Extension

- a. The mutual aid shall continue for an initial period as determined by the Provider, starting from time of arrival. Extensions can be made if warranted and agreed upon by both the Provider and the Recipient via telephone or other means. Extension of mutual aid shall be documented on Attachment X.
- b. Provider may withdraw personnel, equipment and other resources to provide for its own citizens. The Provider will make a good faith effort to notify the Recipient 24 hours prior to resource withdrawal. In the event that such notice is not possible, as much notice as reasonably possible shall be provided.

### D. Related Documents

Attach 2: Wisconsin Act 186

Attach 3: Mutual Aid Request Form

**Section 10: Isolation**

- A. Purpose: To control outbreaks of communicable diseases in health care settings and in the community for symptomatic individuals by use of current CDC guidelines for standard and expanded precautions.
- B. Scope: Isolation measures will be used on all identified suspect, probable, and confirmed cases of communicable diseases for which such measures are known to reduce the risk of transmission to susceptible persons.
- C. Concept of Operations:

**1. LPHD**

- a. Initiate, coordinate, and enforce isolation of cases in home and community settings.
- b. Coordinate provision of basic medical care and daily living needs of isolated cases by referral to appropriate agencies.
- c. Activate and coordinate operation of pre-designated isolation facilities to meet surge.
- d. Ensure safety and training of own staff when encountering suspect, probable, or confirmed cases of communicable diseases.
- e. Coordinate with tribal personnel if an incident occurs on tribal lands.
- f. Notification of emergency responses partners of pertinent Isolation information. (See Append 5, Crisis Communication Plan.)
- g. See statutes relating to Isolation in Legal References, Part D.

**2. DHFS**

- a. Provide guidelines for health care and public health personnel.
- b. Assist LPHDs in clinical assessment of cases and need for isolation.

**D. Related Documents:**

- Attach 4: Infection Control Guidelines for Suspect Cases of Smallpox
- Attach 5: Infection Control Guidelines for Suspect Cases of SARS
- Attach 6: Infection Control Practices in Health Care Settings—Select Agents
- Attach 7: Infection Control Practices for LPHD Staff Visiting Cases on Home Isolation
- Attach 8: Initial Management of Clients with Potential Communicable Diseases
- Attach 9: Sample Voluntary Client Isolation Contract
- Attach 10: Sample Isolation Orders
- Attach 11: Sample of Release from Isolation Form
- Attach 12: Sample Isolation Sign

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## Attach 13: Use of Expanded Precautions

## **Section 11: Quarantine and Home Care**

- A. Purpose: To control the spread of communicable diseases in the community during an infectious disease outbreak while minimizing impact on asymptomatic individuals, families, and communities according to CDC guidelines for standard and expanded precautions.
- B. Scope: Quarantine measures will be used to restrict movement of or separate asymptomatic persons from the community who are determined to be at risk of becoming contagious or are in need of protection from exposure to a communicable disease. Quarantine will be used only for communicable diseases in which such measures are considered beneficial in controlling the disease.
- C. Concept of Operations:
  - 1. **LPHD**
    - a. Evaluate need for and initiate community quarantine measures within their jurisdictions.
    - b. Initiate, coordinate, and enforce quarantine of persons in their jurisdictions.
    - c. Coordinate and assume operations of pre-designated quarantine facilities to meet surge capacity needs.
    - d. Coordinate for daily living needs of persons under quarantine with appropriate agencies.
    - e. Coordinate with tribal personnel if an incident occurs on tribal lands.
    - f. See statutes relating to quarantine in Legal References, Part D.
  - 2. **DHFS**
    - a. Provide current epidemiological information on the disease outbreak so LPHDs can accurately determine quarantine needs.
    - b. Provide consultation and coordinate activities if multiple local jurisdictions or state agencies are involved.

D. Related Documents:

Resource 4: Quarantine Measures in Response to a Suspected Smallpox Outbreak (see Guide C, Part 2, Page 8 of Quarantine Guidelines on CDC website)

Attach 4: Infection Control Guidelines for Suspect Cases of Smallpox

Attach 5: Infection Control Guidelines for Suspect Cases of SARS

Attach 6: Infection Control Practices in Health Care Settings—Select Agents

Attach 7: Infection Control Practices for LPHD Staff Visiting Cases on Home Isolation

Attach 8: Initial Management of Clients with Potential Communicable Diseases

Attach 9: Sample Voluntary Client Isolation Contract

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Attach 10: Sample Isolation Orders

Attach 11: Sample of Release from Isolation Form

Attach 12: Sample Isolation Sign

Attach 13: Use of Expanded Precautions

## **Section 12: Personal Protective Equipment (PPE)**

- A. Purpose: To ensure that personal protective equipment (PPE) needs for infectious agents and chemical agents in the event of bioterrorism, other infectious disease outbreaks and other public health threats and emergencies (BOIDDOOPHTE) and CBRNE (Chemical, Biological, Radiological, Nuclear, Explosive) incidents are included.
- B. Scope: Staff from LPHDs and DHFS are not first responders and would not be responding to incidents (includes response to chemical warfare agents) where Level A PPE is required. (Note: At no time should state or local staff violate confined space entry procedures. In general, these staff should not be entering confined spaces unless they have been specifically trained, certified and have the appropriate equipment.)
  - 1. The level of PPE will be determined case by case for public health staff.
  - 2. Crisis communication activities may include public health staff providing general guidance on PPE for the public and responder workforce (Section 25). The proper selection of PPE is based on many factors, including potential hazards, i.e., is it biological or chemical, physical characteristics of the site, type and phase of chemical (liquid, gas), meteorological conditions, and specific conditions under which tasks will be conducted.
  - 3. Section 10, Isolation, of the PHEP has infection control guidelines that include use of PPE for protection against infectious agents. (See Attachments 4-13.)
  - 4. PPE may also be used in the event of quarantine (Section 11) and Transportation (Section 23).
- C. Concept of Operation:
  - 1. **LPHD**
    - a. PPE (Level C or D) may be needed in the conduction of environmental assessments and collection of environmental samples if trained environmental health staff is available.
    - b. Consult and work with DPH Bureau of Environmental and Occupational Health (BEOH) staff whenever assistance is needed regarding PPE.
  - 2. **DHFS**
    - a. Environmental assessment team members (see Section 28) may need PPE (Level B, C, or D) to evaluate environmental health risks.
    - b. PPE may be needed for the following activities: environmental assessment and sampling (post-incident for determining and demarcating contamination sources), determining the risk of human exposure, overall public health impact and clearing affected areas for occupancy during and after an incident.
- D. Related Documents:



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### Attach 14: Recommended Personal Protective Equipment

**Section 13: Decontamination**

See State of Wisconsin Hospital Bioterrorism Emergency Plan and County Emergency Operations Plans.

## **Section 14: Disposal of Waste**

### **Part I: (Biological) Infectious Waste Disposal**

- A. Purpose: To provide guidance for the safe disposal of infectious waste in the case of a BIODOPHTE/CBRNE incident that may generate a large amount of infectious waste in a short period of time or over a sustained period of time.
- B. Scope: The focus of this section is the disposal of infectious waste. All healthcare operations are to comply with established waste disposal plans as required by NR 526 Medical Waste Management (Resource 5). Existing federal and state waste disposal regulations must be followed as these incidents unfold. Healthcare organizations are also to contact local governmental agencies to determine local regulations.
- C. Concept of Operations:
  - 1. Surge Capacity: In a BIODOPHTE/CBRNE incident, the potential for overloading the waste handling capacity is greatly increased.
    - a. Infectious waste is to be handled and disposed of in the prescribed manner in order to protect the public, the persons handling the waste and the environment. Compliance with NR526 Medical Waste Management (Chapter 526 – Medical Waste Management) and related statutes are to be complied with even when waste volumes have increased significantly. Each organization is to develop protocols in addition to existing waste management plans that address the challenges associated with the increased volume of infectious waste:
      - 1) Supplies: An increased inventory of supplies for general waste handling may be needed quickly when a mass casualty incident takes place. Healthcare organizations will require a greater quantity of biohazard labeled bags, sharps containers, liquid handling containers and all associated supplies. Thus,
        - a) Healthcare organizations are to list the supplies needed for the disposal of biological waste that are in normal inventory and estimate for how long these supplies may last and for how many people.
        - b) Once internal inventories are depleted, organizations may request further supplies from other facilities, if the EOC is not yet activated. (It is assumed that the organization requesting these supplies will have notified the LPHD of the incident.)
        - c) If the EOC is activated, healthcare organizations are to contact the EOC regarding the need for supplies. The EOC will then procure needed supplies from other facilities or other sources or will contact the State to request supplies from the CDC Vendor Managed Inventory Program.
      - 2) Storage: Infectious waste may need to be stored under refrigeration (<42°F) to limit nuisance conditions.

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- a) If the EOC is activated, healthcare organizations are to contact the EOC regarding the need for storage under refrigeration.
  - b) If the EOC is not yet activated, healthcare organizations are to contact the County Emergency Management Office regarding the need for storage under refrigeration.
- 3) Separation of infectious waste from the solid waste stream is to be maintained. Combined waste streams are to be handled as infectious waste. Chemical and radiological wastes must be separated and segregated from infectious waste in order to avoid dual contamination. The following matrix provides guidance regarding handling of infectious waste for various biological agents:
- a) Waste stored on the premises of the healthcare organization must be secure to prevent access by unauthorized persons and to prevent accidental spread of contamination. The designated storage area for infectious waste must display the appropriate 'bio-hazard' symbols. Refrigerated storage areas need to be located away from external air intakes or they need to be maintained with negative airflow.
    - (1) Healthcare organization staff who handle infectious waste are to use the Personal Protective Equipment as outlined in Section 12 of the PHEP.
    - (2) Healthcare organizations are to consult with their medical waste disposal vendors for details of the vendor's ability to provide continued waste disposal services during a mass casualty emergency.
    - (3) Healthcare organizations are to consult with their local Emergency Management Office for storage protocols of infectious waste during a mass casualty incident.
- 4) Record Keeping: Accurate record keeping is to be maintained as set forth in NR526. Maintaining proper chain of custody documents may also be necessary if needed by the law enforcement community.

### D. Related Documents:

1. Resource 5: NR 526 Medical Waste Management

	CATEGORY A	Anthrax	Brucellosis	Glanders	Bubonic Plague	Pneumonic Plague	Tularemia	Q Fever	VIRUSES	Orthopox viruses smallpox / monkeypox)	Venezuelan Encephalitis Encephalitis	SARS	Viral Hemorrhagic Fever	TOXINS	Botulism	Ricin	T-2 Mycotoxin	Staph (SEB)
Waste Disposal Methods																		
<u>Routine Disposal of Infectious Waste</u>		X	X	X	X	X	X	X			X	X	X		X	X	X	X
Use of Biohazard Bags for all used PPE, disposable patient care items/equipment										X								

## Section 14: Disposal of Waste

### **Part II: Chemical Waste Disposal**

- A. Purpose: To provide guidance for the safe disposal of chemical waste in the event chemical(s) are involved in a public health emergency.
- B. Scope: The focus of this section is the proper relocation, treatment, and/or safe disposal of chemical waste to eliminate human exposure and prevent possible long-term exposure and risk.
- C. Concept of Operations:
  1. Notification and Involvement of Local Agencies and Services

In a public health emergency involving chemicals, local first responders are usually onsite to assess the incident and may work with any involved businesses to identify what chemicals may be involved. If there are any human deaths, injuries or people who may require an evaluation for exposure, health care providers (hospitals and clinics) and/or LPHDs are contacted and their resources and expertise are utilized.

#### **2. LPHD**

## Wisconsin Public Health Emergency Plan

- a. Public health is the lead agency in all natural and man-made disasters or emergencies that have immediate or potential long-term public health impacts, including those involving chemicals.
  - b. When emergencies involving chemicals occur at the local level, LPHDs should be notified and apprised of all available information immediately:
    - 1) If there are deaths, injuries, or any evaluation of people by local health care providers, or if any protective actions, such as evacuation or in-place sheltering are being initiated or considered.
    - 2) In any situation where there are personal or public health risks, the LPHD works with health care providers to assess health risks and provide pertinent information to residents and businesses in a manner they can understand and comprehend.
  - c. Examples of LPHD Activities:
    - 1) Serve as the immediate contact point for local public health issues and concerns for dispatch and first responders.
    - 2) Local information link with health care facilities (hospitals, clinics) in the event that there are patients evaluated or treated.
    - 3) Sampling in specific circumstances (i.e. lead, VOCs, mercury).
    - 4) Provide the conduit for state public health staff and resources if not available at the local level.
    - 5) Assessment in some instances (i.e. methamphetamine cases)
    - 6) Provide education on public health risks.
    - 7) Facilitate public meetings for disseminating information, risk communication and ongoing issues.
  - d. In the event that specific resources, such as technical expertise in a particular matter, are nonexistent or are overtaxed at the LPHD, staff from the Division of Public Health Regional Offices, the Central Office in Madison, or the Bioterrorism Consortia can be contacted to provide additional support for the LPHD. If further public health assistance is identified and needed, a request can be made for specific resources and assets to the US Centers for Disease Control and Prevention, Health and Human Services or the Department of Homeland Security.
3. Clinical Considerations
    - a. Patients who are transported to local hospitals and/or clinics by Emergency Medical Services staff and ambulances should be handled in accordance with currently accepted methods to minimize exposure and danger to EMS staff and equipment from chemicals that are on the patients or their clothing.
  4. Environmental Considerations

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- a. In instances where chemicals are involved in releases to the environment and emergency public health protective actions (evacuation, in-place sheltering, public health warnings, advisories etc) are taken or are being considered, the immediate notification and briefing of the LPHD is necessary.
- b. After the chemical(s) release is over or contained, testing of the environment by LPHD may be necessary to allow re-entry to the area affected.
- c. The Department of Natural Resources and the Division of Public Health can assist staff in the LPHD determine if any continuing public health threats (acute or chronic) may be present. These concerns must be addressed and subsequent information provided to potentially affected residents in the community

### D. Related Documents:

Resource 6: Managing Hazardous Materials Incidents, Volume I, Emergency Medical Services: A Planning Guide for the Management of Contaminated Patients.

Resource 7: Managing Hazardous Materials Incidents, Volume II, Hospital Emergency Departments: A Planning Guide for the Management of Contaminated Patients.

Resource 8: Managing Hazardous Materials Incidents, Volume III, Medical Management Guidelines for Acute Chemical Exposures.

## **Section 14: Disposal of Waste**

### **Part III: Radiological Waste Disposal**

See County Emergency Operations Plans for Radiological Incidents.

### **Section 15: Laboratory Procedures**

- A. Purpose: To provide laboratory support to local and state public health agencies in an emergency. Laboratory support entails clinical and environmental testing to detect and identify biological and chemical threats, guidance on specimen collection, packing and transport, guidance on chemical and biological safety, coordination of the response activities of all clinical laboratories in Wisconsin, and sharing of laboratory information and data with the public health community.
- B. Scope: The focus of this section is the laboratory response to public health emergencies. A national model for emergency laboratory response has been developed by the CDC and adopted in Wisconsin. The Wisconsin Laboratory Response Network (WLRN) is a network of more than 120 clinical (sentinel) laboratories and three reference laboratories (Wisconsin State Laboratory of Hygiene (WSLH), Milwaukee Health Department Laboratory, and Marshfield Clinical Research Foundation Laboratory) prepared to respond to a public health emergency. As the lead laboratory of the WLRN, the WSLH coordinates and integrates network activities with local and state public health response. The WSLH will update the laboratory portion(s) of Wisconsin's Response Plan (currently, *General Anthrax Response Protocol*, dated May 24, 2002, prepared by: Wisconsin Division of Emergency Management, Wisconsin Division of Public Health, Wisconsin Department of Justice, and the Wisconsin State Laboratory of Hygiene). In addition, the WSLH is developing a plan for collaborative emergency response with local public health laboratories, the Wisconsin Veterinary Diagnostic Laboratory, Department of Agriculture, Trade and Consumer Protection Bureau of Laboratory Services, and the State Crime Laboratory.
- C. Concept of Operations:
  - 1. Event-Related Activities
    - a. **LPHD**
      - 1) Access event-specific information on specimen collecting, packing, transport and testing from the WSLH
      - 2) Notify WLRN laboratories within their jurisdiction of the event
      - 3) Provide guidance to sentinel laboratories, healthcare providers and other responders on patient and specimen selection, and collection and transport of specimens.
      - 4) Package and transport specimens in compliance with regulations.
      - 5) Disseminate result reports to laboratories and healthcare providers.
      - 6) Participate in laboratory response debriefing.
    - b. **DHFS**
      - 1) Access event-specific information on specimen collecting, packing, transport and testing specific from the WSLH.



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- 2) Notify WSLH of the event and related response planning activities (teleconferences, videoconferences, etc.).
- 3) Provide guidance to local public health and the WSLH on criteria for patient and specimen selection.
- 4) Disseminate reports to local public health; disseminate CDC results to WSLH and local public health.
- 5) Inform WSLH when event has concluded or passed the acute stage.
- 6) Participate in laboratory response debriefing.

### c. **WSLH**

- 1) Perform testing of emergency-related specimens; in cases where the WSLH does not have the required testing capability, locate laboratories with the testing capability and facilitate specimen transport and testing at those laboratories.
- 2) Provide ongoing information and guidance to sentinel laboratories regarding their roles and responsibilities, specimen collection, testing and transport, and laboratory safety.
- 3) Provide written instructions on specimen collection and proper packing and transport of specimens for testing to state and local public health agencies and other response partners.
- 4) Coordinate the use of statewide repositories and alternative courier systems and the utilization of local public health laboratory field representatives; maintain the inventories of repositories.
- 5) Provide telephone and/or written results, including WLRN and CDC results, to state and local public health agencies and specimen submitters; provide written results, including WLRN and CDC results, to local public health agencies, in addition to submitters, for terrorism-related specimens.
- 6) Conduct a laboratory response debriefing to evaluate the laboratory response and identify improvements within one month after the emergency has passed.

**Section 16: Strategic National Stockpile**

- A. Purpose: To redistribute federal assets of the Strategic National Stockpile (SNS) to LPHDs, tribal health centers and medical treatment facilities in response to bioterrorism or other public health emergencies.
- B. Scope: To outline the roles and responsibilities within the State of Wisconsin for the reception and use of the assets of the Strategic National Stockpile Program and aid the development of uniform local and regional plans. This plan is to be consistent with existing federal, state and local policies, ordinances, statutes and plans. It is anticipated that the Wisconsin SNS plan (Append 1) will undergo constant change as information and recommendations evolve on the national, state and local levels.
- C. Concept of Operations:
  - 1. **LPHD**
    - a. Identify a liaison to communicate with Receiving Staging Storing (RSS) warehouses.
    - b. Secure SNS material commensurate with threat.
    - c. Request material utilizing SNS order forms or automated system utilizing existing EOC communication infrastructure.
    - d. Receive SNS Material. Note: Controlled substances will not be delivered to mass clinics. Acknowledge receipt and report any discrepancies to the EOC upon receipt. If requesting large quantities, have necessary equipment to offload and move material.
    - e. Initiate backup transportation plan if necessary.
    - f. Manage inventory by tracking utilization of assets. Communicate on hand inventory to EOC at least daily.
    - g. Return all unused SNS material. Material should be packaged and a pickup requested through the EOC.
  - 2. **DHFS**
    - a. Maintain lists of designated public health personnel to train and supervise volunteers to disassemble, organize and repackage SNS materials and prepare them for transportation at the RSS warehouse.
    - b. Obtain seven facilities to be used as RSS warehouses.
    - c. Staff and operate a RSS warehouse.
    - d. Provide a liaison to the State Emergency Operation Center (EOC).
    - e. Coordinate, track and maintain medical material inventory and recommend additional material.
    - f. Transport SNS assets to LPHDs and treatment facilities in accordance with local PHEP.

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g. Coordinate public health public information activities related to the SNS.

### D. Related Documents:

Append 1: Division of Public Health Strategic National Stockpile Plan

**Section 17: Mass Clinics**

- A. Purpose: To operate a mass clinic to vaccinate/prophylaxis a population in response to a terrorist incident or other public health emergency.
- B. Scope: Mass clinics are those planned, activated and operated by a LPHD in a given facility as part of a larger public health emergency response during a defined period of time.
- C. Concept of Operations:
  - 1. **LPHD**
    - a. Secure facilities for mass clinics.
    - b. Mobilize volunteers to assure staffing of mass clinic.
    - c. With JPIC as coordinating body, address media interest in clinic site(s), publicize clinic location, operation and other important information.
    - d. Initiate specific mass clinic plans: dispense medications or administer vaccine.
    - e. Manage client information.
  - 2. **DHFS**
    - a. Establish medical order to provide vaccination or prophylaxis.
    - b. Request additional supplies for mass clinics.
    - c. Provide technical support/assistance to LPHDs operating mass clinics.
    - d. Act as liaison between state EOC and other state and federal agencies.
    - e. Provide LPHDs with communication templates.
- D. Related Documents:
  - Append 2: Mass Clinic Plan
  - Append 3: Wisconsin Pandemic Influenza Plan

**Section 18: Public Health Role in Triage**

- A. Purpose: To identify and quantify in a mass exposure or illness situation ill, injured, and/or exposed individuals outside of traditional pre-hospital/emergency room/clinic/hospital care so that they may be treated appropriately, and the spread of any communicable illness reduced or prevented.
- B. Scope: This PHEP will address the public health role in triage that pertains to illnesses and exposures atypical of triage practices of the Emergency Medical System. Such triage may occur at mass vaccination or prophylaxis clinics, or at sites specifically set up for triage in an outbreak or epidemic, or in the more traditional emergency settings. The expected outcomes of triage are that a number of persons will be transported to a medical facility for further care, a number will require mortuary services, and others will be referred to home or another facility for monitoring, isolation or quarantine as appropriate. Health care facilities, emergency medical services and health departments must work together so that their mutual goals of timely appropriate care and outbreak investigation and control may be accomplished.
- C. Concept of Operations:
  - 1. **LPHD**
    - a. In conducting a mass clinic, include staff to triage prior to entrance of the clinic and coordinate transport to medical facility available.
    - b. Depending on the disease, immediate isolation of possible cases may be required. Have a system in place to receive triage count and case status information from clinicians and hospitals and transmit in a timely fashion to DHFS.
    - c. Cross-reference to Section 25, Crisis Communications; ensure message is issued to public of where to go if you have symptoms vs. going to the mass clinic.
  - 2. **DHFS**
    - a. Monitor numbers and case status of triaged patients statewide using data provided by LPHDs.
    - b. Provide to clinicians and health departments state wide current epidemiologic information on any infectious disease outbreak or incident, case definitions and supplemental documentation, consultation, and coordination of activities if multiple local jurisdictions or state agencies are involved.
    - c. Report to federal and to other state agencies as necessary.
- D. Related Documents:
  - Attach 15: Field Triage Record

**Section 19: Responder Workforce**

- A. Purpose: To temporarily increase the capacity to organize and utilize state, regional, and local resources necessary to respond to and assure the health and safety of the population in a public health incident.
- B. Scope: The responder workforce will include licensed and non-licensed healthcare professionals and other volunteers that will assist in a public health incident.
- C. Concept of Operations:
  - 1. **LPHD**
    - a. Enlist Volunteers
      - 1) Local enlisting process
        - a) Establish a volunteer staging area,
        - b) Contact volunteers,
        - c) Indicate to the volunteers where to report, and what to bring,
        - d) Coordinate announcements with the media regarding need for volunteers, and where volunteers should report.
      - 2) Wisconsin Emergency Assistance Volunteer Registry (WEAVR):
        - a) Local Health Officers, Tribal Health Directors, HRSA Preparedness Representatives, and Consortia Program Coordinators have the ability to query WEAVR for those health professional volunteers within the jurisdiction that have indicated they are willing to be contacted by LPHDs.
        - b) If a county EOC is established, the public health personnel within the EOC may initiate a request for DPH to query WEAVR for all health professional volunteers outside the LPHD jurisdiction.
        - c) To query WEAVR:
          - (1) Go to the Health Alert Network:  
<https://www.han.wisc.edu/index.html>
          - (2) Click on Admin
          - (3) Click on WEAVR
          - (4) Select WEAVR Search
    - b. Deployment of Volunteers
      - 1) In an emergency it is required that medical volunteers licensure be verified. Licensure will be coordinated through the County EOC at the volunteer staging area.
      - 2) At the volunteers staging area a list will be maintained which includes:
        - a) Name of volunteer,

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- b) Estimated time of arrival,
  - c) Estimated length of service,
  - d) Current employer,
  - e) Job title/responsibilities,
  - f) License number (which will be given to the EOC for verification if internet verification is not available at the staging area),
  - g) Volunteer role in an incident.
- 3) When volunteers check in at staging area:
- a) Identify/Credential the volunteer when they arrive onsite (picture ID with name or work badge),
  - b) Provide an incident briefing and just-in-time training,
  - c) Give assignments/provide role descriptions,
  - d) Identify work director for volunteers and make sure volunteers understand scope of responsibility,
  - e) Provide directions/instructions for where/how volunteers are to sign/in out each day.
- c. EOC Coordination of Licensure and Credentialing
- 1) The HAN licensure database and the physician profile of the American Medical Society National Practitioner Database have restricted access and can be accessed when a county EOC is activated.
  - 2) All requests for licensure of a healthcare professional will be verified through the EOC. Access to databases is available only to representative(s) at the County EOC and to hospitals.
  - 3) Hospitals retain the right to credential licensed healthcare professionals who report directly to the hospital according to emergency credential protocols.
  - 4) For the purpose of disaster credentialing of physicians, it is not necessary to access data from the National Practitioner Database or to complete a criminal background check.
- d. Follow-up with Volunteers
- 1) Verify any support (i.e. mental health referrals) needed for volunteers (see Section 24),
  - 2) Solicit input on processes they contributed to in the incident,
  - 3) Attempt to conduct a debriefing with volunteers,
  - 4) Conduct evaluation/thank you for volunteers.

## 2. DHFS

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In an event, DPH leadership will provide overall coordination, direction and work with incident command and communications personnel.

- a. Maintain and query the Wisconsin Emergency Assistance Registry (WEAVR) which is an up-to-date list of public health professionals by professional discipline who have agreed to assist in a public health emergency.
- b. Provide signed medical orders from a DPH Chief Medical Officer for the delegation of medical orders to LPHDs.
- c. Assure mechanisms are in place to report incidents of personal injury incurred by the workforce during the public health emergency.
- d. Assure that DHFS level workforce understand their roles and responsibilities in an incident.
- e. Assure there are signed legal and administrative agreements (Medical Orders, Mutual Aid, and EMAC) with appropriate state-level partners, such as Emergency Government and Military Affairs.
- f. Provide to the local incident commander criteria in which to assess the responder workforce resources needed and how this information will be rapidly relayed to the State Health Officer to advise the Governor to mobilize additional and sufficient resources to the community and/or federal FEMA resources if need be.

### D. Related Documents:



**Section 20: Incident Specific Training (Just in Time)**

- A. Purpose: To identify and provide incident specific training which may be necessary to respond to bioterrorism, other infectious disease outbreaks, and other public health threats and emergencies.
- B. Scope: The focus of this section is providing incident specific training that will address the needs of the responding workforce. When a fast breaking and/or slow developing incident occur, there may be the need to educate responding agencies, volunteers, and/or the public around the unique issues that the incident has triggered. All incident specific trainings need to be consistent with curricula being utilized in Wisconsin and follow all local, state, and federal policies and procedures.
- C. Concept of Operations:
  - 1. **LPHD**
    - a. Maintain communication with all staff involved in the incident to determine if any incident specific training is needed.
    - b. Assess all information received related to training and determine the level and type of incident specific training needed.
    - c. Coordinate with local Emergency Management, other LPHDs, hospitals / clinics and the remaining workforce, including volunteers, to deliver consistent training to the responding workforce that addresses the identified needs.
    - d. All trainings will be conducted in accordance with established training curricula.
    - e. Develop a PHEP to ensure all responding workforce members receive incident specific training and proper documentation of training received.
    - f. Communicate with DHFS to assist in coordinating resources to effectively meet incident specific training needs.
  - 2. **DHFS**
    - a. Routinely analyze incoming training needs and assist in finding resources to meet identified needs.
    - b. Routinely consult with federal and state agencies as needed to coordinate incident specific training regionally and federally.
    - c. Provide approved and appropriate incident specific training materials to the consortia training coordinators.
    - d. Through the Consortia, make available appropriate staff to assist the consortia in meeting the training needs of the responding workforce.
- D. Related Documents:

## **Section 21: Special Needs Populations**

Definition of special populations: Any individual, group, or community, who's physical, mental, emotional, cognitive, cultural, ethnic, socio-economic status, age, language or other circumstance, creates barriers understanding and/or the ability to manage the effects of disaster in the manner in which the general population has been requested to proceed.

- A. Purpose: To assure that special population needs are recognized and receive appropriate intervention and response during a public health incident.
- B. Scope: Those individuals and/or groups within a specific region who require additional needs addressed.
- C. Concept of Operations: Communication/Notification, transportation, treatment and care will be addressed to meet the needs of special populations.

### **1. LPHD**

- a. Each LPHD is to identify special populations (geriatric, pediatric, language barrier, and medically fragile) that are present in their jurisdiction and develop PHEP to address the needs of the population in a public health incident.
- b. LPHD will coordinate with human service organizations to meet the communication/notification, transportation, and treatment needs of special populations in a public health incident.

### **2. DHFS**

Through collaboration with the Special Populations Community Coalition, guidelines will be provided to the LPHDs for communication/notification, transportation, and treatment needs of special populations.

### **D. Related Documents:**

Attach 16: Special Populations Checklist

**Section 22: Residential Facilities**

- A. Purpose: To coordinate with human services and emergency management to assure that the needs of individuals within residential facilities are met during a public health incident.
- B. Scope: Residential facilities are defined as nursing homes, rehabilitation and psychiatric hospitals, assisted living facilities and other such facilities licensed or certified by the State of Wisconsin.
- C. Concept of Operations:
  - 1. **LPHD**
    - a. The LPHD, in collaboration with the Regional Hospital Bioterrorism Preparedness Teams, may serve as a resource to the residential facility to ensure that the residential facility will appropriately utilize the resources of both the LPHD and healthcare facilities in a mass casualty incident. They may provide guidance on:
      - 1) Treatment,
      - 2) How the outbreak of a contagious disease can be contained.
    - b. LPHD assures that individuals in residential facilities receive appropriate prophylaxis during a public health incident.
    - c. LPHD will coordinate with human services and emergency management to provide essential services for persons in residential facilities.
- D. Related Documents:

**Section 23: Transportation**

- A. Purpose: To ensure that transportation resources needed during public health emergencies are included and available in response and recovery plans.
- B. Scope: For the purposes of PHEP, transportation resources include, but are not limited to, transportation resources which are necessary to evacuate persons affected or threatened by incidents involving BOIDDOOPHTE. Transportation resources may also include facilitating the movement of identified essential personnel, equipment and supplies to prevent or intervene in the protection of the public's health.
- C. Concept of Operations:
  - 1. **LPHD**
    - a. Emergency Medical Service agencies will provide transportation of patients as designated by the Incident Command System or the County/tribal Emergency Operations Center as described in the Health and Medical Annex of the County Emergency Operations Plan (EOP).
    - b. Emergency Medical Service agencies will assist hospitals with transfer of patients as described in the State of Wisconsin Hospital Bioterrorism Preparedness Plan, Section 6: Hospital Receiving, Triage, Transportation.
    - c. LPHDs will be responsible for providing technical health-related information (e.g., communicating any known risks and precautionary measures) to responders which includes, but is not limited to, transportation providers and the appropriate individuals at the point of destination as described in the Health and Medical Annex of the County EOP.
  - 2. **DHFS**
    - a. Provide assistance and support to LPHDs in public health emergencies where local transportation resources are not sufficient to meet identified needs.
    - b. Work with state agencies, including Wisconsin Emergency Management, to identify a resource list of such services that may be used in support of local public health emergencies.
- D. Related Documents:

See County Emergency Operations Plans and Annexes for Transportation Resources that may already be listed.

**Section 24: Mental Health Services**

- A. Purpose: To minimize the negative psychosocial effects of public health threats and emergencies on individuals (including people with special needs), families, communities, service systems, and the emergency response as a whole.
- B. Scope: Public Health will coordinate with Human Services to assure the psychosocial well being of survivors, community members, and responders in an incident. Public Health will coordinate with human service responders to assure:  
1) accurate information about the potential psychosocial effects of public health threats and emergencies; and 2) effective procedures for preventing and addressing those effects.
- C. Concept of Operations:
  - 1. **LPHD**
    - a. In the event of an incident, coordinate with the county human services authority immediately to activate its response under appropriate annexes of the County Emergency Management Plan and to facilitate notification of DHFS and mobilization of the state emergency human services response.
    - b. Provide any information requested by state, regional, and local human services authorities regarding the scope, status, and effects of the threat or emergency, including any response measures that have a potential for psychological destabilization of more vulnerable populations.
    - c. Inform, consult, and coordinate with mental health/substance abuse/human services authorities and professionals to meet the needs of victims, survivors, responders and the general public.
    - d. Provide accurate, understandable, non-stigmatizing, non-sensationalizing, and culturally and linguistically appropriate public information regarding public health threats and emergencies to minimize the risk of destabilization and “normalize” common responses to crisis.
  - 2. **DHFS**
    - a. Mobilize the state’s emergency human service response system to meet the needs of institutions under DHFS responsibility and local and regional response systems according to the terms of Wisconsin’s Emergency Human Services Response: A Disaster Mental Health, Substance Abuse, and Human Services Plan (Append 4).
    - b. Provide support, technical assistance and coordination assistance to local and regional emergency human services, Incident Command, the Emergency Operations Center, Public Health, Tribal Health, hospitals, and DHFS facilities, for planning, response and recovery activities.
- D. Related Documents:

Append 4: Wisconsin’s Emergency Human Services Response: A Disaster Mental Health, Substance Abuse, and Human Services Plan.

## **Section 25: Crisis Communication**

Note: “Crisis Communications” refer to any communications provided by a public authority during a disaster incident.

- A. Purpose: To ensure that during a BOIDDOOPHTE event risk communication principles will be utilized in delivering information to the public through every appropriate channel.
- B. Scope: For the purposes of this PHEP, crisis and emergency risk communication is defined as the efforts by health experts to provide information to allow an individual, stakeholder, or an entire community to make the best possible decisions about their well-being, within a narrow time constraint.
- C. Concept of Operations:
  - 1. **LPHD**
    - a. In an emergency situation, consistent up-to-date messages are key in educating the public, getting emergency staff to their assigned duties and in enabling emergency plans to be conducted effectively. In a public health emergency, the State Emergency Operations Center (EOC) will be opened and a State Joint Information Center (JIC) will be activated. A JIC is a location for agencies involved in the incident to coordinate public information activities and a place for the media to access current information. As local EOCs are opened, JICs may be activated at the local level. LPHDs will have the following communication responsibilities:
      - 1) The responsibility to inform local communities about community specific information related to the incident will fall to LPHDs, in close coordination with local partners such as Emergency Management.
      - 2) As EOCs /JICs are activated at the local level throughout the state, LPHDs should designate primary and back-up spokespersons to share community-specific information with the public and the media.
      - 3) LPHDs will assure a PIO is designated at each local EOC/JIC to coordinate information and communication activities with the State EOC/JIC. Regular communication with State EOC/JIC may be accomplished via phone conference, fax, email, Wisconsin Health Alert Network, radio, blackberry and, in some instances, in person.
      - 4) LPHDs will assign staff to closely coordinate information with neighboring LPHDs to ensure consistent messages are delivered to the community.
      - 5) All communications will be conducted in accordance with established principles of crisis and emergency risk communication.
  - 2. **DHFS**
    - a. In the event of a public health emergency the State Emergency Operations Center will be opened and a State Joint Information Center will be activated. The State JIC is the location for all agencies involved in the incident to coordinate statewide public information activities and a place

## Wisconsin Public Health Emergency Plan

for the media to access current information. DHFS and its state agency partners will have the following responsibilities:

- 1) The responsibility to keep the public and media informed about the incident and actions the state is taking to respond will be coordinated among the various agencies involved at the State JIC.
- 2) The State EOC/ Joint Information Center will issue press releases and conduct press conferences regularly as information is learned about the incident. All press releases will be shared with local EOCs.
- 3) DHFS will utilize a variety of communication tools to ensure that messages are delivered effectively. Communication may take place via teleconference, Wisconsin Health Alert Network, web cast, radio, postings on the DHFS web site, broadcast fax, email, 211 Wisconsin and, in some instances, public meetings.
- 4) Public information responsibilities will be shared among the Wisconsin Department of Health and Family Services, Wisconsin Emergency Management, LPHDs, hospitals and other affected organizations. The common goals of these agencies, through the implementation of PHEP, are:
  - a) To protect the health and welfare of the public by communicating emergency information in a timely, compassionate and accurate manner;
  - b) To produce an informed public and to minimize confusion about the incident;
  - c) To maintain public confidence in the ability of government to minimize the impact of the incident, to the extent possible, by providing emergency information that is correct, consistent and credible, and by doing so promptly and openly;
  - d) Public information will be made available in multiple languages to reach affected populations;
  - e) All communications will be conducted in accordance with established principles of crisis and emergency risk communication.

### D. Related Documents:

Append 5: Crisis Communication Plan

**Section 26: Integrated Communications**

- A. Purpose: To identify the primary and redundant communications capabilities that are required in a LPHD for that department to adequately respond to an emergency and to identify the extent to which that department has those resources available.
- B. Scope: For the purposes of PHEP, the communications channels include internet, HAN and other databases, web, landline telephone, cellular telephone, satellite telephone, pager, fax, email, two-way-radio, and other technologies as they are developed.

C. Concept of Operations:

**1. LPHD**

- a. During an incident, each LPHD is responsible for the management and coordination of its own communications.
  - 1) Each LPHD shall have available a listing of alternate communications systems, including, but not limited to:
    - a) EMS, mutual aid and emergency management radio frequencies,
    - b) Preferred method to contact other LPHDs and consortia representatives (pager, phone, switchboard, 24/7 call-list, etc.),
    - c) Disaster control telephone number(s) and/or Incident Command Center,
    - d) Cellular or power failure telephone numbers for the above locations.
  - 2) During an incident, the LPHD in the jurisdiction where the incident is occurring shall serve as the communications hub (unless the local EOC is activated).
    - a) That LPHD is responsible for relaying manual or electronic communications to the other participant tribes, LPHDs and DHFS as applicable.
    - b) Participant LPHD communications will be directed to the communications hub. The communications hub will log all communicated information including, but not limited to: number called, date, time, name of contact and summary of information relayed.
  - 3) If the local EOC is activated for the incident said EOC shall serve as the communications hub and all communications will be directed and logged accordingly to and from the EOC.

**2. DHFS**

- a. DHFS will provide guidance and communications infrastructure resources such as secure web portal, call tree alerting system, secure web directory



## Wisconsin Public Health Emergency Plan

for listing communication systems, radio frequencies, preferred contact methods and emergency contact telephone numbers. This guidance will include current and emerging communications technologies.

- b. DHFS will provide forward and backwards communications through the internal DHFS call lists to LPHDs as well as the local EOC if activated.
- c. State listing of local public health 24/7 call lists are updated on a regular basis.

### D. Related Documents:

**Section 27: Mass Fatality Management**

- A. Purpose: To successfully activate and manage a County Mass Fatality Mortuary Plan (CMFMP) to insure effective, safe and humane:
1. Recovery and identification of bodies,
  2. Determination of cause and manner of death,
  3. Collection of forensic evidence (including information relevant to determining the source of biological contamination in a BIODOOPHTE event),
  4. Notification of next of kin,
  5. Emergency disposition of bodies to prevent spread of disease,
  6. Release of bodies for final disposition,
  7. Availability of critical incident debriefing for all mortuary workers,
  8. Completion of legal death-related documents,
  9. Communications between the Coroner/Medical Examiner Office (CMEO) and federal, state and local government agencies and with the family assistance center (if applicable).
- B. Scope: A mass fatality disaster is defined as a number of deaths from a specific incident that overwhelms the capabilities of the CMEO and local mortuary service providers. That number will differ from county to county. Deaths will be investigated and processed under the requirements listed in Wis. Statute s. 59, 69 and 979.

For the purposes of this PHEP, the CMEO is assumed to be the CMFMP coordinator. A model county plan is included as an appendix to this PHEP (Append 6). The CMFMP may be located in an annex or appendix (usually in Annex H) of the county emergency management plan. The specific roles of CMEO, LPHDs, tribal health agencies, local funeral directors, crematory operators, local vital records registrars, DMORT teams and other personnel are specified in the CMFMP.

C. Concept of Operations:

To facilitate understanding of the roles of public health agencies and health care facilities in a mass fatality disaster, the Concept of Operations is separated into three parts: 1. CMFMP design, testing, universal operations and activation in common disasters (e.g., plane crashes, tornadoes, fires); 2. Bioterrorism and other CBRNE-related disasters; 3. Pandemic disasters.

1. CMFMP design, testing, universal operations and activation in common disasters.
  - a. County Coroner/Medical Examiner Office
    - 1) Will design, periodically test, and, when appropriate, activate and manage a comprehensive CMFMP that includes:

## Wisconsin Public Health Emergency Plan

- a) Specific numbers of deaths that trigger activation of the CMFMP on various levels (from mutual aid to state DMORT team activation and regional DMORT team),
- b) Specific instructions and contact information for activation of the CMFMP,
- c) Security information for staging areas and personnel,
- d) Command structure and responsibilities, including interface with unified incident command and local and state public health agencies,
- e) Pre-assigned potential staging areas for temporary morgue(s) and family assistance center(s),
- f) Pre-determined sources of equipment (e.g. PPEs, refrigeration trucks, computers, body bags, etc.),
- g) Pre-determined sources of personnel (forensic experts, volunteers, etc.),
- h) Pre-incident, intra-incident and post-incident task lists,
- i) Expenditure accounting system,
- j) Pre-determined methods of mass dispositions including plans for group funerals, memorial services and grief assistance mechanisms for survivors.

### b. **DHFS**

- 1) Upon request from the CMEO, will provide assistance to county CMEO, funeral directors and local vital registrars with designing and testing CMFMP (through the Bureau of Health Information and Policy/Vital Records Section).
- 2) Upon request from the CMEO, will provide on-site or remote intra-incident assistance to the CMEO, funeral directors and local vital records registrars (through the Bureau of Health Information and Policy/Vital Records Section).
- 3) Will provide a web-based communications platform to connect the CMEO with other state agencies (through the HAN and Casepoint).
- 4) Will provide CMEOs with information on how to detect the possibility of a BIODOOPHTE-related death.
- 5) Will provide CMEOs with information on best practices for safe-handling of confirmed or suspected contaminated human remains (specific to the type of contamination).
- 6) Will, in the event of a mass fatality event so large that decomposition of human remains becomes a public health risk, notify the CMEO if the Communicable Disease Chief Medical Officer determines that the

## Wisconsin Public Health Emergency Plan

statutory 48 hour waiting period for cremation can be waived to prevent the spread of communicable disease or other biohazard under provisions of Wis. Statute s. 979.10.

### c. **LPHD**

- 1) Will participate in CMFMP design at the request of the CMEO to ensure proper communications with public health agencies in the event of a BIODOOPHTE event.
- 2) Will participate in CMFMP exercises at the request of the CMEO.
- 3) Will provide the CMEO with intra-incident and post-incident assistance for any public health concerns that arise in the management of the CMFMP.
- 4) Will assist the CMEO in collaboration with the Red Cross and the Salvation Army, other volunteer organizations, and the State Office of Mental Health for additional support services related to personnel critical incident debriefing and family grief assistance.
- 5) If necessary, will invoke powers given to a public health authority under Wis. Statute 157.055 (2) to assist with the management of the incident during a declared public health emergency.

## 2. Bioterrorism and other CBRNE-related disasters

### a. County Coroner/Medical Examiner Office

- 1) Will retain investigatory jurisdiction of all fatalities resulting from suspected acts of terrorism and will investigate such deaths as homicides under Wis. Statute s. 940.
- 2) Will handle all evidence collected according to standard forensic protocols for a homicide investigation, including standard chain of custody procedures for deaths due to any type of terrorism.
- 3) Will examine bodies or allow examination of bodies in hospital or other appropriate examination settings in accordance with standard hospital and morgue safety procedures, including decontamination, if appropriate.
- 4) Will make arrangements to use appropriate rooms within area hospitals and nursing homes to examine in-patients/residents who have died as a result of bioterrorism.
- 5) Will determine the necessity for an autopsy based on standard protocols and input from local and state public health officials.
- 6) Will take measures to ensure that standard operating procedures regarding universal precautions for blood and body fluids, infection control and isolation are used for autopsies and the handling of corpses.

## Wisconsin Public Health Emergency Plan

- 7) Will arrange for transport of bodies of all other victims or suspected victims (persons dying outside of a hospital or nursing home) of bioterrorism to an appropriate site for examination.
- 8) Will arrange for regional hazmat teams to establish mass decontamination facilities, if necessary, to decontaminate prior to autopsy or burial. Individual hospitals may utilize hospital-based decontamination facilities for this same purpose.
- 9) Will follow standard policies and procedures regarding notification of next of kin, if possible.
- 10) Will release bodies for normal final disposition (according to current CMEO procedure and state laws) if there is no contamination or risk of disease transmission.

### b. **DHFS**

- 1) Will notify the CMEO if the Communicable Disease Chief Medical Officer determines that the statutory 48 hour waiting period for cremation can be waived to prevent the spread of communicable disease or other biohazard under provisions of Wis. Statute ss. 157.055 (2) (a) and 979.10.
- 2) Will notify the CMEO if the Communicable Disease Chief Medical Officer determines that cremation or other form of final disposition becomes mandatory to prevent the spread of communicable disease or other biohazard under provisions of Wis. Statute ss. 157.055 (2) (c).
- 3) Will provide the CMEO with a mechanism for electronic keying, storage and real-time transmission of data for all incident-related deaths for case tracking purposes.

### c. **LPHDs/Tribal Health Agencies**

- 1) Will work with the CMEO, regional hazmat teams and mortuary service providers to insure safe transport and disposal of infected or contaminated human remains and associated waste material.
- 2) Will work with regional hazmat teams to ensure proper decontamination of affected facilities.
- 3) Will assist the CMEO in collaboration with the Red Cross and the Salvation Army, other volunteer organizations, and the State Office of Mental Health for additional support services related to personnel critical incident debriefing and family grief assistance.
- 4) If necessary, will invoke powers given to a public health authority under Wis. Statute 157.055 (2) to assist with the management of the incident during a declared public health emergency.

## 3. Pandemic Disasters

### a. County Coroner/Medical Examiner Office

## Wisconsin Public Health Emergency Plan

- 1) Will assume jurisdiction of investigating deaths occurring outside of a hospital or nursing home during a pandemic event.
- 2) Will use the HAN communications network so that information regarding autopsy procedures, diagnosis and final disposition of the deceased is conveyed as quickly and securely as possible.
- 3) Will work with all of the associations of funeral directors in Wisconsin to develop rapid systems of communication so that funeral directors throughout the state have immediate access to recommendations (developed by the communicable disease chief medical officer with the CMEO) for care of the deceased.
- 4) Will release bodies for normal final disposition (according to current CMEO procedure and state laws) if there is no contamination or risk of disease transmission.
- 5) Will follow standard policies and procedures regarding notification of next of kin, if possible.

### b. **DHFS**

- 1) Will notify the CMEO if the Communicable Disease Chief Medical Officer determines that the statutory 48-hour waiting period for cremation can be waived to prevent the spread of communicable disease or other biohazard under provisions of Wis. Statute ss. 157.055 (2) (a) and 979.10.
- 2) Will notify the CMEO if the Communicable Disease Chief Medical Officer determines that cremation or other form of final disposition becomes mandatory to prevent the spread of communicable disease or other biohazard under provisions of Wis. Statute ss. 157.055 (2) (c).
- 3) Will provide the CMEO with a mechanism for electronic keying, storage and real-time transmission of data for all incident-related deaths for case tracking purposes.

### c. **LPHD**

- 1) Will work with the CMEO, regional hazmat teams and mortuary service providers to insure safe transport and disposal of infected or contaminated human remains and associated waste material.
- 2) Will work with regional hazmat teams to ensure proper decontamination of affected facilities.
- 3) Will assist the CMEO in collaboration with the Red Cross and the Salvation Army, other volunteer organizations, and the State Office of Mental Health for additional support services related to personnel critical incident debriefing, and family grief assistance.
- 4) If necessary, will invoke powers given to a public health authority under Wis. Statute 157.055 (2) to assist with the management of the incident during a declared public health emergency.

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### D. Related Documents:

Resource 9: Coroner/Medical Examiner Listing

Resource 10: Forensic Pathologist Listing

Resource 11: Emergency Contact Listing for State Vital Records Mass Fatality Plan

Resource 12: Forensic Odontologist Listing

Append 6: Model County Mass Fatality Mortuary Plan

**Section 28: Environmental Health and Risks**

- A. Purpose: To ensure that during an event of bioterrorism, other infectious disease outbreaks and other public health threats and emergencies (BOIDDOOPHTE) and CBRNE (Chemical, Biological, Radiological, Nuclear, Explosive) incidents, environmental health concerns and risks are addressed.
- B. Scope: The role of Environmental Health is to prevent effects on humans following the release of chemical, biological, or radiological agents. Exposure to these agents could occur through the routes of inhalation, ingestion or skin contact. The effects could be either toxic or infectious. Following a release, risks are assessed based on the amount of the agent present, whether people will be exposed to the agents, and the predicted effects of the agent. Environmental health staff will use monitoring, sampling, and decontamination strategies to both assess and prevent risks from the release of harmful agents.
- C. Concept of Operations:
  - 1. **LPHD**
    - a. Conduct environmental assessments and collect environmental samples if trained environmental health staff is available.
    - b. Consult and work with DPH Bureau of Environmental and Occupational Health (BEOH), the Wisconsin State Laboratory of Hygiene (WSLH), Department of Natural Resources (DNR), and hazmat staff whenever assistance is needed regarding environmental assessments/investigations.
    - c. Have notification numbers for DHFS (608-258-0099) and Wisconsin Emergency Management (WEM) (1-800-943-0033) accessible. \_
  - 2. **DHFS**
    - a. Environmental assessment team members comprised of DPH, the Department of Natural Resources (DNR), the Department of Agriculture, Trade and Consumer Protection (DATCP) and WSLH staff will evaluate environmental health risks to include the need for and the collection of environmental samples. Members will consult with the first responders (when appropriate), the local hazmat unit of the local fire department, and work with LPHD and tribal health centers (when appropriate) to evaluate the situation. These agencies will assess the need for control measures and also identify environmental health risks after the incident.
    - b. If the environmental assessment extends beyond the capability or capacity of state resources, the DHFS or other appropriate agency(s) will request assistance from the Wisconsin National Guard, the Environmental Protection Agency (EPA), Agency for Toxic Substances and Disease Registry (ATSDR) and, if necessary, Occupational Safety and Health Administration (OSHA). These agencies can provide assistance in conducting environmental investigations, determining the need for mitigation and management, and recommending the appropriateness of reentry.



## Wisconsin Public Health Emergency Plan

- c. In the event of suspected terrorism, the Federal Bureau of Investigation (FBI), and/or DPH and/or the DNR and/or the local hazmat unit might collect environmental samples. These agencies have varying capabilities for collecting, packaging and testing in the field. The FBI may request assistance from state or federal staff with expertise in specific biohazards and/or chemicals to ensure sample collection is completed without harming the agent(s) of interest. As appropriate, sample collection and packing will be discussed with the WSLH or other laboratories. The collection, packaging and transportation of environmental specimens will be done in accordance with existing procedures that assures both safety and chain of custody, as well as the integrity of the samples for analysis.
- d. Samples will be forwarded to the closest regional laboratory that is appropriately certified to perform the necessary testing. This may be analytical work performed on unknown samples or confirmatory work to verify field results. Depending on the situation and sample, testing may be done at the WSLH, DATCP, Crime labs, Veterinary Diagnostic, or the CDC. The state labs can coordinate and communicate with one another to determine which lab should receive the sample based on laboratory capability and capacity, if necessary. The capacity of local and regional laboratories to evaluate both clinical and environmental specimens will be surveyed on an annual basis.
- e. The DPH BEOH in conjunction with DATCP will coordinate control/disposal of animals or biological vectors.

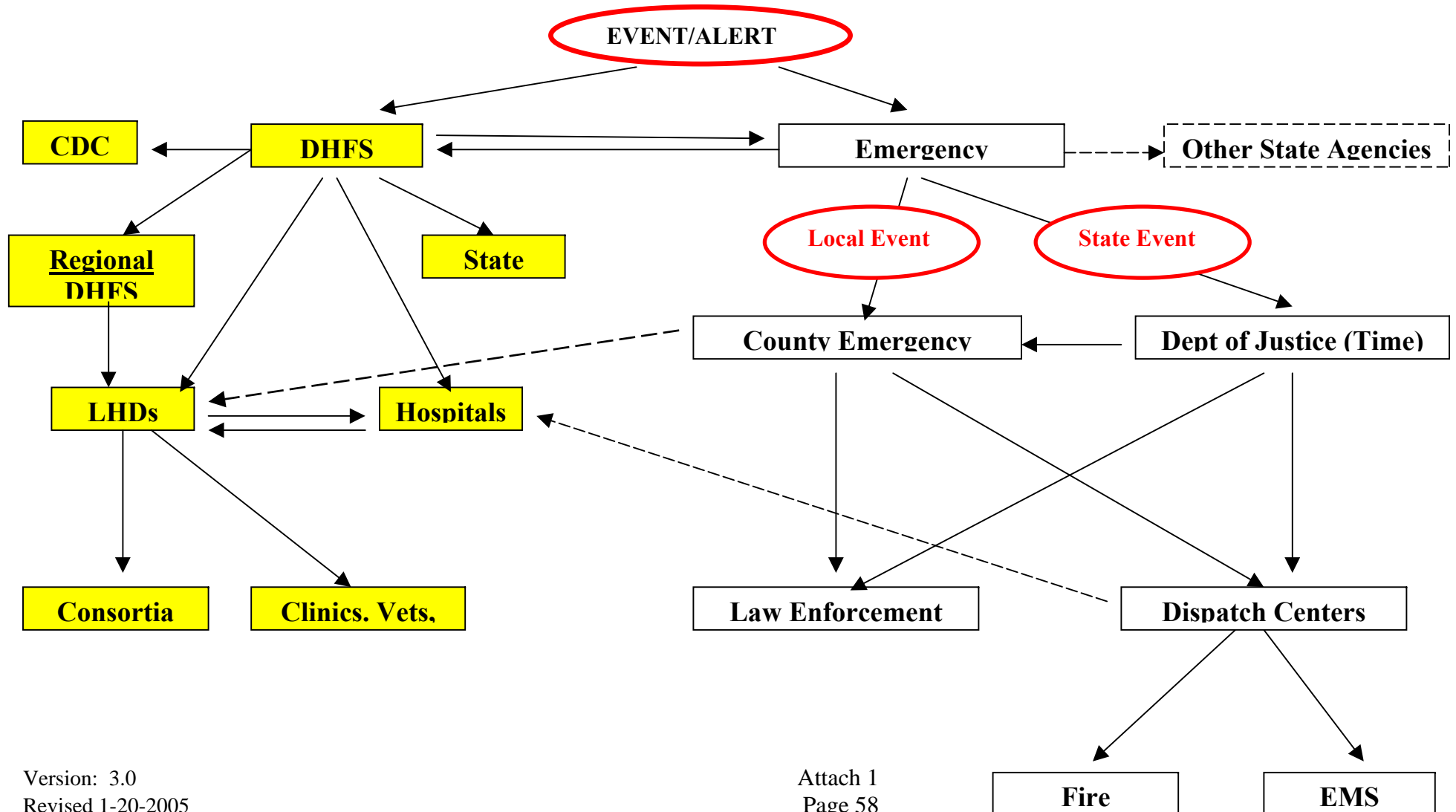
### D. Related Documents:

**Section 29: Incident Termination**

- A. The Incident Commander or EOC, if activated, will notify all participating agencies and institutions involved under their PHEP that the incident is terminated.
- B. Each participant who has been notified of termination of incident will in turn notify any associated support providers that the incident is terminated.

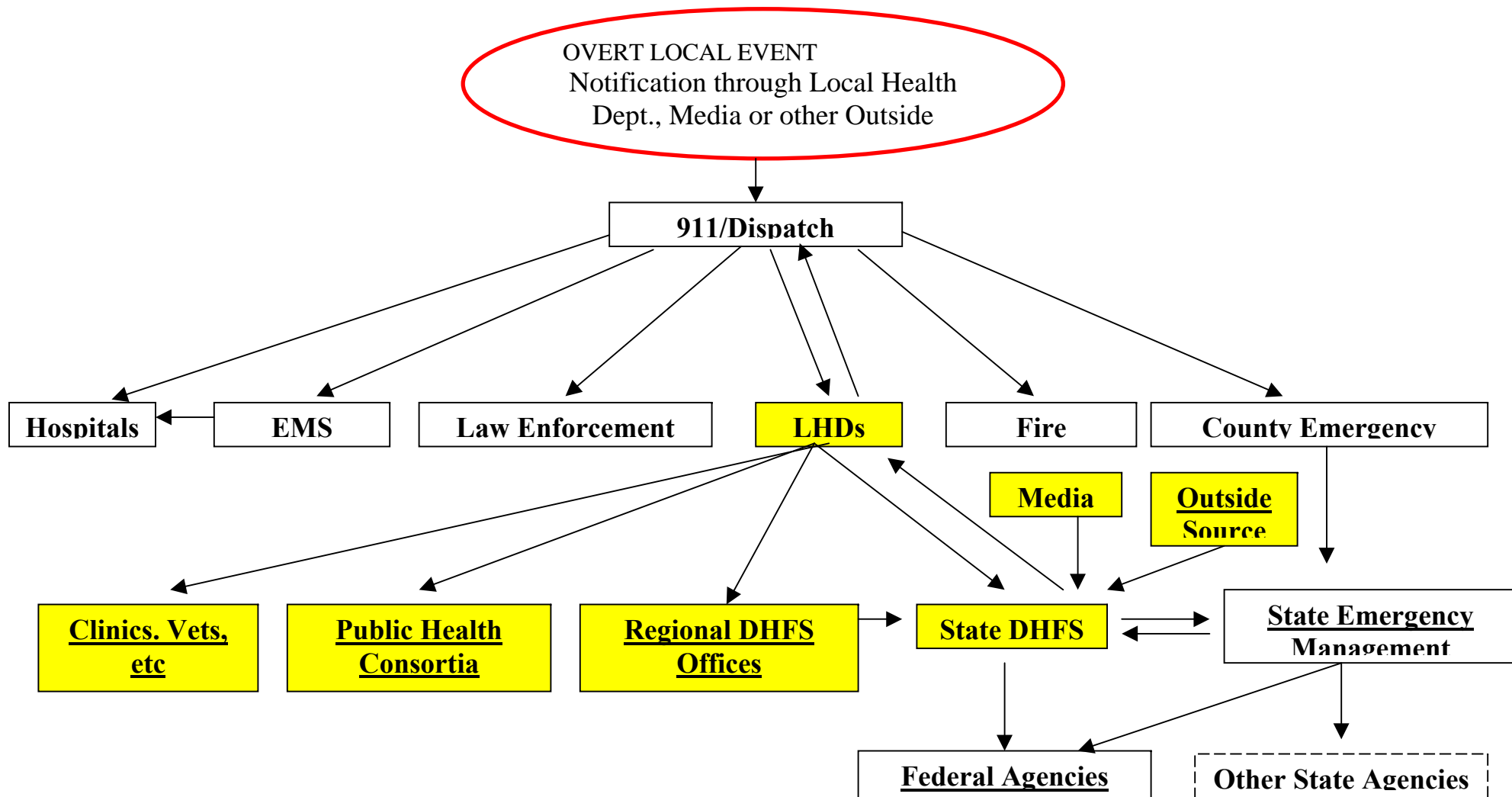
**Revised 11/21/03**

## 24/7 Emergency Notification System for Health Event (Federal/State Origination) Statewide Capability



Revised 11/21/03

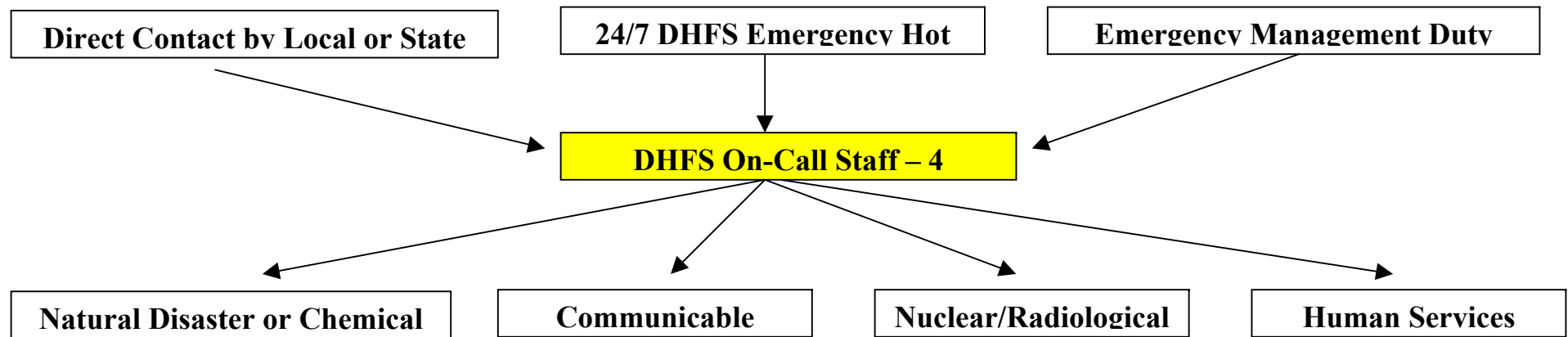
## 24/7 Emergency Notification System for Health Event (Local Origination)



**DHFS EMERGENCY NOTIFICATION AND RESPONSE PLAN**

**EVENT/ALERT**

**Revised 11/21/03**



**DHFS Actions**

**Contact Appropriate**

- 1. Local Health Depts.**
- 2. Regional DHFS staff**
- 3. DHFS Central Office Staff**
- 4. Emergency Management Duty Officer**

**Services Available**

- 1. Surveillance**
- 2. Investigation**
- 3. Emergency Lab Services**
- 4. State Coordination of Activities**
- 5. On-Site Assistance**
- 6. Prevention**

2003 Senate Bill 120

Date of enactment: **April 7, 2004**  
Date of publication\*: **April 21, 2004**

## 2003 WISCONSIN ACT 186

**AN ACT** *to renumber* 250.07; *to amend* 20.465 (3) (e), 166.03 (2) (a) 1., 2. and 3., 166.03 (5) (a), 166.03 (10) and 250.042 (1); and *to create* 15.197 (13), 20.435 (1) (c), 66.0312, 66.03125, 66.0314, 166.02 (6m) and (6r), 250.07 (1m) and 252.06 (10) (c) of the statutes; **relating to:** creating a public health council, reimbursement for quarantine costs, intrastate mutual aid, requiring use of the incident command system in an emergency, exemption from liability during a state of emergency, and making appropriations.

*The people of the state of Wisconsin, represented in senate and assembly, do enact as follows:*

PREFATORY NOTE: This bill was prepared for the Joint Legislative Council's Special Committee on the Public Health System's Response to Terrorism and Public Health Emergencies.

### Public Health Council

The bill creates a 23-member Public Health Council in the Department of Health and Family Services (DHFS). The council must include representatives of health care consumers, health care providers, health professions educators, local health departments and boards, public safety agencies, and the Public Health Advisory Committee established by the Secretary of DHFS.

The council is required to advise DHFS, the governor, the legislature, and the public on progress in implementing DHFS's 10-year public health plan and coordination of responses to public health emergencies.

### Reimbursement for Quarantine Costs

The bill requires the state to reimburse local health departments for all of their expenses incurred in quarantining a person outside his or her home during a declared state of emergency related to public health and not reimbursed from federal funds.

Reimbursement would be made from one of 2 state sum sufficient appropriations: (1) a DHFS appropriation created in this bill, if the governor has called a state of emergency

related to public health under s. 166.03 (1) (b) 1. and has designated DHFS as the lead state agency; or (2) an existing Department of Military Affairs (DMA) appropriation, if the governor has called a state of emergency related to public health under s. 166.03 (1) (b) 1. but has not designated DHFS as the lead state agency.

### Intrastate Mutual Aid

The bill establishes a statewide system of mutual aid for emergency management programs, emergency medical services (EMS) programs, fire departments, and local health departments.

Currently, law enforcement agencies are authorized to enter into mutual aid agreements with other law enforcement agencies in the state, under s. 66.0313 (2), stats. The personnel of the agency furnishing assistance are considered employees of the requesting agency while providing assistance. Law enforcement agencies may also enter into mutual aid agreements with law enforcement agencies in adjacent states.

The state is party to a compact for interstate emergency management mutual aid, but there is no specific statutory provision for intrastate emergency management mutual aid. The statutes provide that counties, towns, and municipalities may cooperate through an intergovernmental contract to provide and finance emergency management services and combine offices. Generally, this contracting has been between adjacent counties.

Fire departments throughout the state operate under mutual aid agreements with other in-state fire departments that are not specifically provided for in statutes. These mutual

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\* Section 991.11, WISCONSIN STATUTES 2001-02 : Effective date of acts. "Every act and every portion of an act enacted by the legislature over the governor's partial veto which does not expressly prescribe the time when it takes effect shall take effect on the day after its date of publication as designated" by the secretary of state [the date of publication may not be more than 10 working days after the date of enactment].

aid agreements appear to fall under the general language of s. 66.0301, stats., which permits municipalities to enter into intergovernmental cooperation agreements. A provision of the Wisconsin administrative code relating to fire department dues provides that a fire department may use mutual aid agreements as a means of providing fire protection services. [s. Comm. 14.48 (1) (b) 1., Wis. Adm. Code.]

Some local fire departments are also parties to interstate fire mutual aid agreements under the general statutory provision authorizing municipal interstate cooperation agreements. [s. 66.0303, stats.]

Under the bill, upon the request of a county, city, village, or town, or a person acting under an incident command system (ICS), the personnel of any emergency management program, EMS program, fire department, or local health department may assist the requester within the requester's jurisdiction, without regard to any other jurisdictional provision. The entity employing the personnel acting in response to a request for assistance is responsible for the personnel-related costs incurred in providing the assistance. The bill defines "incident command system" using language from the definition in s. Comm. 30.01 (16), Wis. Adm. Code, and from the state of Washington's ICS statutes.

#### Incident Command System

The bill requires utilization of the ICS in managing emergencies and training of specified personnel in the use of the ICS.

Under current law:

1. Department of Commerce administrative rules governing fire department incident management require that every public sector fire department establish an ICS which has written guidelines applying to all fire fighters involved in emergency operations and which identifies fire fighter roles and responsibilities relating to the safety of operations. These rules define "incident command system" as an organized system of roles, responsibilities, and suggested operating guidelines used to manage and direct emergency operations. Under these rules, fire departments are required to train all fire fighters involved in emergency operations in the ICS and assign safety responsibilities to supervisory personnel at each level of operations. [ss. Comm. 30.14 (1) (a) to (c) and 30.01 (16), Wis. Adm. Code.] A footnote to the incident command rule provision indicates that suggested operating guidelines have been developed and published by the Wisconsin Technical Colleges System Board.

2. Department of Natural Resources administrative rules relating to hazardous substance discharge response provide that when deemed appropriate to effectively coordinate all actions at the scene of a hazardous substance discharge, an ICS shall be implemented. In these rules, "incident command system" is defined as an organized approach used to effectively control and manage operations at the scene of a hazardous substance discharge. [ss. NR 702.09 (2) and 702.03, Wis. Adm. Code].

3. The state Emergency Operations Plan (EOP) developed by the Division of Emergency Management (known as "Wisconsin Emergency Management" or "WEM") provides that an ICS "will be used in disaster response". However, the EOP does not indicate specifically what the ICS system entails or who must use it. The EOP further states that unified command is to be used in situations which affect multiple jurisdictions or multiple agencies within a jurisdiction or which require response by multiple levels of government. The EOP notes that these command and control systems require the participation of the chief elected officials. The EOP also provides that as the lead state agency for direction and control, WEM is to direct and coordinate emergency operations to support incident command at the local level.

At present, there are no statutory provisions pertaining to incident command.

This bill does the following:

1. Defines the term "incident command system", using language from the definition in s. Comm. 30.01 (16), Wis. Adm. Code, and from the State of Washington's incident command statutes.

2. Requires that an incident command system be used by all emergency response agencies, including local health departments, in responding to, managing, and coordinating multi-agency or multi-jurisdiction incidents, when a state or local emergency declaration has been made or in any other emergency situation.

3. Requires the Adjutant General, in developing state-wide emergency training and exercise programs, to provide training to officers and employees of local health departments and to elected and appointed local government officials in use of the ICS in managing emergencies. The Adjutant General must consult with DHFS regarding the ICS training for local health department personnel. The bill requires the Adjutant General to utilize federal funding to provide this training, to the extent possible.

#### Exemption From Liability

Current law provides an exemption from liability for a person who provides equipment or services during a state of emergency declared by the governor for the death of or injury to any person or damage to any property caused by his or her actions. The immunity does not apply if the person acted intentionally or with gross negligence. Under current law, the exemption from liability applies if the person provides the equipment or services under the direction of the governor, the adjutant general, or the head of emergency management services in any county, town, or municipality.

The bill amends the law so that the exemption from liability also applies if the person provides the equipment or services under the direction of DHFS, if that department is designated by the governor as the lead state agency to address a public health emergency, or at the direction of a local health department that is acting as the agent of DHFS.

**SECTION 1.** 15.197 (13) of the statutes is created to read:

**15.197 (13) PUBLIC HEALTH COUNCIL.** There is created in the department of health and family services a public health council consisting of 23 members, nominated by the secretary of health and family services, and appointed for 3-year terms. The council shall include representatives of health care consumers, health care providers, health professions educators, local health departments and boards, federally recognized American Indian tribes or bands in this state, public safety agencies, and, if created by the secretary of health and family services under s. 15.04 (1) (c), the public health advisory committee.

**SECTION 2.** 20.435 (1) (c) of the statutes is created to read:

**20.435 (1) (c) Public health emergency quarantine costs.** A sum sufficient to reimburse local health departments under s. 252.06 (10) (c) 1.

**SECTION 3.** 20.465 (3) (e) of the statutes is amended to read:

**20.465 (3) (e) Disaster recovery aid; public health emergency quarantine costs.** A sum sufficient to pay the

state share of grants to individuals and, to make payments to local governments as defined in 42 USC 5122 (6) under federal disaster recovery programs as authorized in s. 166.03 (2) (b) 8., and to reimburse local health departments under s. 252.06 (10) (c) 2.

**SECTION 3m.** 66.0312 of the statutes is created to read:

**66.0312 Local health departments; mutual assistance.** (1) In this section “local health department” has the meaning given in s. 66.0314 (1) (e).

(2) (a) Subject to sub. (3), upon the request of a local health department, the personnel of any other local health department may assist the requester within the requester’s jurisdiction, notwithstanding any other jurisdictional provision.

(b) If a request for assistance is made under par. (a), payment for the requested services shall be made by one of the following methods:

1. If an agreement under s. 66.0301, or any other agreement between the parties, for the payment of such services exists, the terms of the agreement shall be followed.

2. If no agreement described under subd. 1. for the payment of such services exists, the governmental unit that receives the assistance is responsible for the personnel or equipment costs incurred by the responding agency if the responding agency requests payment of those costs.

(3) This section does not apply during a state of emergency declared by the governor under s. 166.03 (1) (b) 1.

**SECTION 3p.** 66.03125 of the statutes is created to read:

**66.03125 Fire departments; mutual assistance.**

(1) In this section “fire department” has the meaning given in s. 66.0314 (1) (c).

(2) (a) Subject to sub. (3), upon the request of a fire department, the personnel of any other fire department may assist the requester within the requester’s jurisdiction, notwithstanding any other jurisdictional provision.

(b) If a request for assistance is made under par. (a), payment for the requested services shall be made by one of the following methods:

1. If an agreement under s. 66.0301, or any other agreement between the parties, for the payment of such services exists, the terms of the agreement shall be followed.

2. If no agreement described under subd. 1. for the payment of such services exists, the governmental unit that receives the assistance is responsible for the personnel or equipment costs incurred by the responding agency if the responding agency requests payment of those costs.

(3) This section does not apply during a state of emergency declared by the governor under s. 166.03 (1) (b) 1.

**SECTION 4.** 66.0314 of the statutes is created to read:

**66.0314 State of emergency; mutual assistance.**

(1) In this section:

(a) “Emergency management program” means the emergency management program of a city, village, town, or county, under s. 166.03 (4) (a).

(b) “Emergency medical services program” means a program established under s. 146.55.

(c) “Fire department” means any public organization engaged in fire fighting or a private sector employer fire company or fire department organized as a nonstock, nonprofit corporation under ch. 181 or ch. 213 without the input of a municipality.

(d) “Incident command system” means a functional management system established to control, direct, and manage the roles, responsibilities, and operations of all of the agencies involved in a multi-jurisdictional or multi-agency emergency response, which may include authorities designated by a participating tribe or band.

(e) “Local health department” has the meaning given in s. 250.01 (4), and also includes an entity designated by a participating tribe or band as a local health department.

(fe) “Tribe or band” means a federally recognized American Indian tribe or band in this state.

(2) (a) If the governor declares a state of emergency under s. 166.03 (1) (b) 1., upon the request of a city, village, town, or county, or a person acting under an incident command system, the personnel of any emergency management program, emergency medical services program, fire department, or local health department may assist the requester within the requester’s jurisdiction, notwithstanding any other jurisdictional provision.

(b) If a request for assistance is made under par. (a), the governmental unit that receives the assistance is responsible for the personnel or equipment costs incurred by the responding agency to the extent that federal, state, and other 3rd-party reimbursement is available if all of the following apply:

1. The responding agency meets the personnel and equipment requirements in the state plan under s. 166.03 (2) (a) 1.

2. The responding agency requests payment of those costs.

**SECTION 5.** 166.02 (6m) and (6r) of the statutes are created to read:

166.02 (6m) “Incident command system” means a functional management system established to control, direct, and manage the roles, responsibilities, and operations of all of the agencies involved in a multi-jurisdictional or multi-agency emergency response.

(6r) “Local health department” has the meaning given in s. 250.01 (4).

**SECTION 6.** 166.03 (2) (a) 1., 2. and 3. of the statutes are amended to read:

166.03 (2) (a) 1. Subject to approval by the governor, develop and promulgate a state plan of emergency management for the security of persons and property which shall be mandatory during a state of emergency. In devel-



oping the plan, the adjutant general shall seek the advice of the department of health and family services with respect to the emergency medical aspects of the plan. The plan shall specify equipment and personnel standards, and shall require the use of the incident command system, and specify the type of incident command system, by all emergency response agencies, including local health departments, during a state of emergency declared under sub. (1) (b) 1. or s. 166.23 (1) or in any other multi-jurisdictional or multi-agency emergency response.

2. Prescribe and carry out statewide training programs and exercises to develop emergency management proficiency, disseminate information including warnings of enemy action, serve as the principal assistant to the governor in the direction of emergency management activities and coordinate emergency management programs between counties. The training programs shall include training in managing emergency operations utilizing the incident command system for local government officials, officers, and employees whose duties include responding to emergencies, including officers and employees of local health departments. The adjutant general shall consult with the department of health and family services regarding the provision of incident command system training to local health department personnel. To the extent possible, the adjutant general shall utilize federal funding to provide incident command system training.

3. Furnish guidance and develop and promulgate standards for emergency management programs for counties, towns and municipalities, and prescribe nomenclature for all levels of emergency management. The standards shall include a requirement that county, town, and municipal emergency management programs under sub. (4) (a) utilize the incident command system during a state of emergency declared under sub. (1) (b) 1. or s. 166.23 (1) or in any other multi-jurisdictional or multi-agency emergency response.

**SECTION 7.** 166.03 (5) (a) of the statutes is amended to read:

166.03 (5) (a) The head of emergency management services in each county, town and municipality shall for his or her respective county, town or municipality, develop and promulgate emergency management plans consistent with state plans, direct the emergency management program and perform such other duties related to emergency management as are required by the governing body and the emergency management committee of the governing body when applicable. The emergency management plans shall require the use of the incident command system by all emergency response agencies, including local health departments, during a state of emergency declared under sub. (1) (b) 1. or s. 166.23 (1) or in any other multi-jurisdictional or multi-agency emergency response.

**SECTION 8.** 166.03 (10) of the statutes is amended to read:

166.03 (10) EXEMPTION FROM LIABILITY. No person who provides equipment or services under the direction of the governor, the adjutant general or the head of emergency management services in any county, town or municipality or federally recognized American Indian tribe or band in this state, the department of health and family services if that department is designated by the governor under s. 166.03 (1) (b) 1., or a local health department acting under s. 251.05 (3) (e) during a state of emergency declared by the governor is liable for the death of or injury to any person or damage to any property caused by his or her actions, except where the trier of fact finds that the person acted intentionally or with gross negligence. This subsection does not affect the right of any person to receive benefits to which he or she would otherwise be entitled under the worker's compensation law or under any pension law, nor does it affect entitlement to any other benefits or compensation authorized by state or federal law.

**SECTION 9.** 250.042 (1) of the statutes is amended to read:

250.042 (1) If the governor declares a state of emergency related to public health under s. 166.03 (1) (b) 1. and designates the department as the lead state agency to respond to that emergency, the department shall act as the public health authority during the period of the state of emergency. The department shall ensure that the emergency operations during the state of emergency are conducted using the incident command system required under s. 166.03 (2) (a) 1. During the period of the state of emergency, the secretary may designate a local health department as an agent of the department and confer upon the local health department, acting under that agency, the powers and duties of the public health authority.

**SECTION 10.** 250.07 of the statutes is renumbered 250.07 (1).

**SECTION 11.** 250.07 (1m) of the statutes is created to read:

250.07 (1m) The public health council shall monitor implementation of any document developed by the department under sub. (1) (a) and shall advise the governor, the legislature, the department, and the public on progress in implementing the document and coordination of responses to public health emergencies.

**SECTION 12.** 252.06 (10) (c) of the statutes is created to read:

252.06 (10) (c) All expenses incurred by a local health department, or by an entity designated as a local health department by a federally recognized American Indian tribe or band in this state, in quarantining a person outside his or her home during a state of emergency related to public health declared by the governor under s.

## 2003 Senate Bill 120

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## 2003 Wisconsin Act 186

166.03 (1) (b) 1. and not reimbursed from federal funds shall be paid for under either of the following, as appropriate:

1. If the governor designates the department as the lead state agency under s. 166.03 (1) (b) 1., from the appropriation under s. 20.435 (1) (c).

2. If the governor does not designate the department as the lead state agency under s. 166.03 (1) (b) 1., from the appropriation under s. 20.465 (3) (e).

### **SECTION 15. Nonstatutory provisions.**

(1) PUBLIC HEALTH COUNCIL. Notwithstanding the

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length of terms specified for the members of the public health council under section 15.197 (13) of the statutes, as created by this act, the initial members of the public health council shall be appointed by the first day of the 4th month beginning after the effective date of this subsection for the following terms:

(a) Seven members for terms expiring on July 1, 2005.

(b) Eight members for terms expiring on July 1, 2006.

(c) Eight members for terms expiring on July 1, 2007.

Attachment 3

STATEWIDE MUTUAL AID AGREEMENT FOR  
EMERGENCY RESPONSE/RECOVERY

PART I: REQUEST FOR ASSISTANCE

Emergency or disaster event: \_\_\_\_\_

Recipient: \_\_\_\_\_

1. General description of the event:  
(Attach latest local Situation Report or summarize briefly.)
  
2. Identification of the emergency services function(s) for which assistance is needed (e.g., fire, law enforcement, emergency medical, transportation, communications, public works and engineering, building inspection, mass care, resource support, search and rescue etc.) and the particular type of assistance needed.
  
3. Identification of the public infrastructure system(s) for which assistance is needed (e.g., sanitary sewer, potable water, storm water systems, etc.) and the type of work assistance required.
  
4. The amount and type of personnel, equipment, materials, and supplies needed and a reasonable estimate of the length of time they will be needed:
  
5. Identify the Recipient's representative or point-of-contact.

Authorized Representative for Recipient: \_\_\_\_\_

Title: \_\_\_\_\_

Date: \_\_\_\_\_ Time: \_\_\_\_\_

After completion of Part I, fax this entire form to the potential provider and to the State EOC: (608) 242-3299.

Wisconsin Public Health Emergency Plan

PART II: ASSISTANCE TO BE PROVIDED

Provider: \_\_\_\_\_

The request for assistance from \_\_\_\_\_ has been received.

(Check one box only.)

☐

Assistance can be provided as follows:

1. Personnel: (List primary point-of-contact/team leader and all personnel. Provide titles and Social Security #s for each. Be specific about the deployment related costs for which reimbursement will be requested.)
  
  
  
  
  
  
  
  
  
  
2. Equipment:
  
  
  
  
  
  
  
  
  
  
3. Place of Arrival:
  
  
  
  
  
  
  
  
  
  
4. Estimated Date and Time of Arrival:
  
  
  
  
  
  
  
  
  
  
5. Estimated Date and Time of Departure:
  
  
  
  
  
  
  
  
  
  
6. The above terms and information have been coordinated with the Recipient's point of- contact:

\_\_\_\_\_ Phone: \_\_\_\_\_

☐

Assistance cannot be provided at this time. Briefly explain why.

Authorized Representative for Provider: \_\_\_\_\_

Title: \_\_\_\_\_

Date: \_\_\_\_\_ Time: \_\_\_\_\_

After completion of Part II, fax this entire form to the requesting locality and to the State EOC: (608) 242-3299.

PART II: ASSISTANCE TO BE PROVIDED - CONTINUATION  
(OPTIONAL)

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PART III: RECIPIENT'S APPROVAL

Assistance in accordance with the terms and conditions described in Part II of this agreement is hereby:

☐ Accepted

☐ Declined

(Check only one)

Authorized Representative for Recipient: \_\_\_\_\_

Title: \_\_\_\_\_

Date: \_\_\_\_\_ Time: \_\_\_\_\_

After completion of Part III, fax this entire form to the locality offering assistance and to the State EOC: (608) 242-3299.

## **Infection Control Guidelines for Suspect Cases of Smallpox**

### **I. Introduction**

These protocols focus on the management of a suspect case of smallpox, occurring in the absence of an already recognized outbreak, that is, a case that may represent the index case of a bioterrorist event.

The primary purpose of airborne and contact precautions is to confine and contain the infectious agent to the greatest degree possible while continuing to meet the needs of the patient and simultaneously minimizing the risk of contagion to others.

#### **Definitions:**

A “**case**” means a person determined to have a particular communicable disease on the basis of clinical or laboratory criteria or both. HFS145.03 (2)

A “**suspect case**” means a person thought to have a particular communicable disease on the basis of clinical or laboratory testing. HFS145.03 (27)

“**Close contacts**” are defined as persons, who were in close proximity to the suspect case. All persons in the same room (*i.e., waiting room*) as the suspect case should be considered “close contacts”.

“**Isolation rooms**” are defined as airborne infection isolation (AII) rooms that have a minimum of 6-12 air exchanges per hour (ACH) and direct exhaust to the outside, which is located more than 25 feet from an air intake and from areas where people may pass. If air cannot be exhausted directly to the outside more than 25 feet from an air intake and from areas where people may pass, then air should be filtered through an appropriately installed and maintained HEPA filter. These rooms should be tested monthly (and daily when in use) to verify negative airflow. Current rooms may have 6 ACH but newly constructed or renovated rooms must have a minimum of 12 ACH.

Note: If rooms in older facilities must be “switched on” to provide 6- 12 air exchanges per hour, then a method must be implemented to ensure that this occurs and is monitored.

“**Preidentified room**”: In hospitals that do not have “AII” that meet the above criteria, an enclosed private room(s) should be preidentified for “isolating” patients with fever and rash illnesses to minimize exposure to other patients and staff (*e.g., an examination room at the end of a hallway*). A transportation route from the Emergency Department to this preidentified room also is to be established.

**“Vaccine eligible”: meeting all current criteria for indications for vaccination, with no contraindications. The most recent criteria from CDC will be used to determine vaccine eligibility of individuals.**

## II. Initial Evaluation of Suspect Case

A. Any patient presenting for evaluation in the Emergency Department with fever and an acute, generalized vesicular or pustular rash will be immediately identified, masked and placed in “AII” or a pre-identified room.

### B. Recognition of a Suspect Case

1. Reception staff and all medical care staff are to be trained to be on alert for patients with any rash illnesses and will immediately place the suspect case in a “AII” or a pre-identified room, when no “AII” is available.
  - a. The poster, “Evaluating Patients for Smallpox - Acute, Generalized Vesicular and Pustular Rash Illness Protocol”, should be available at the reception/registration desk.

Note: The poster can be found at

<http://www.bt.cdc.gov/agent/smallpox/diagnosis/evalposter.asp>

2. Once a suspect case has been placed in “AII”, the following steps are to be implemented:
  - a. Signage is placed at the entrance of the Emergency Department, stating that any patient with fever and rash immediately notify reception staff.
  - b. All ambulance and pre-hospital support staff are to pre-notify the Emergency Department, if transporting patient with fever and rash illnesses.

### C. Isolation of Suspect Case

1. A surgical mask is to be placed immediately on patients, presenting with fever and rash illnesses
2. Airborne and Contact Precautions are to be employed.

### D. Clinical Assessment of the Risk of Smallpox

1. The clinical assessment of smallpox will follow the CDC criteria for determining whether the suspect case is at low, moderate or high risk for smallpox (**see Guidelines for Assessing Vesicular and Pustular Rashes, page 14.**)

## Wisconsin Public Health Emergency Plan

- a. For **low risk patients**, as defined in the guidelines (especially if chickenpox or disseminated herpes zoster is the likely diagnosis, based on history and physical examination), varicella laboratory testing is optional and the patient is to be kept isolated, using airborne and contact precautions, as per the hospital's varicella protocol.

Transfer of Specimens either to a laboratory within the facility or to an outside laboratory are to follow the guidelines of the Wisconsin State Laboratory of Hygiene.

Note: The protocols for the transfer of specimens can be found at:

<http://www.iata.org/dangerousgoods/index>  
<http://hazmat.dot.gov/rules.htm>

For patients determined to be at low risk for smallpox, but for whom the diagnosis is uncertain, laboratory testing for varicella zoster virus antigen (using rapid DFA or PCR antigen tests) and/or other conditions should be considered as indicated clinically.

**If rapid varicella antigen testing or a consultation is needed, the local health department in the county/city, in which the hospital is located, is to be contacted.**

- b. For moderate risk patients, as defined in the guidelines, **the local health department in the county/city, in which the hospital is located, is to be contacted immediately**. The local health department will respond to the hospital request for assistance by providing case interview, contact tracing and public health consultation on management of the patient and all hospital "close contacts". In addition, **an infectious disease or dermatology consult is to be sought** as well as rapid testing for varicella (DFA or PCR testing for varicella antigen) if available, and for other diseases as clinically indicated.

If specialty consultation and/or rapid testing is not available, or the diagnosis remains uncertain, the local health department will assist in determining the likelihood of smallpox and arrange for rapid diagnostic testing for varicella (to help differentiate chickenpox from smallpox) and/or variola, if indicated.

Specialty consultation, if not locally available, is available through the Wisconsin Division of Public Health, Bureau of Communicable Disease:

- 1) Business Hours: 608-267-9003 (Note: Request to speak with the Epidemiologist "on call").



- 2) Outside Business Hours: 608-258-0099 (Note: This telephone number is for health professionals only and should not be made available to the public.)

- c. For **high-risk patients**, as defined in the guidelines, **the local health department in the county/city, in which the hospital is located, is to be contacted immediately**. The local health department will respond to the hospital request for assistance by providing case interview, contact tracing and public health consultation on management of the patient and all hospital personnel. In addition, **an infectious disease or dermatology consult is to be sought**.

### III. Management of the Suspect Case, Pending Laboratory Test Results for Smallpox

Hospitals will take the following steps for managing suspect **moderate** or **high-risk** patients to protect other patients, staff and visitors from smallpox infection, while awaiting the arrival of the local health department.

- A. The suspect case is to remain isolated on airborne and contact precautions in the Emergency Department. If the local health department staff agree that the suspect case is at **moderate** or **high risk** for smallpox and that variola testing is indicated, the suspect case will be admitted and moved to a “AII” or held in the pre-identified room, until transferred to another facility with “AII.”

It is recommended that the inpatient AII have a toilet and sink and a bath or shower

- B. Once the hospital has utilized all its “AII” for suspect cases, it is to transfer other suspect cases in need of admission to another facility with “AII”.
- C. Infection control personnel and the on-call hospital administrative staff are to be immediately notified regarding the suspect case. If not already involved, consultations are to be requested from dermatology and/or infectious disease specialists.
- D. Isolation signs, noting the need for airborne and contact precautions, are to be displayed outside the suspect case room and the door to the suspect case room is to be kept closed (self-closing doors are preferable).
- E. All personal protective equipment (*e.g., gowns, eye protection, gloves, and fit-tested N95 or higher respirators*) is to be stocked outside the door to the suspect case room. Hand hygiene products, such as disinfectant gels, are to be available for use by all staff and visitors outside the door to the suspect case room.
  1. Eye protection is to be worn when within 3 (three) feet of the coughing suspect case. (*Note: Eye protection should be such that it protects the eyes from splashes from above or from the sides of the eye protection.*)

## Wisconsin Public Health Emergency Plan

2. If available, the suspect case is to be placed in “AII” with an anteroom that has a sink, so that persons leaving the room can dispose of their protective clothing and equipment and wash their hands before exiting to the hallway.
  3. In the absence of an anteroom, gowns and gloves are to be removed inside the suspect case room and discarded in a waste receptacle just inside the room by the door. A separate waste receptacle is to be placed immediately outside the suspect case room for disposal of used respirators.
- F. The number of persons who enter the suspect case room, is to be minimized as much as possible. Visitors are to be limited to:
1. Designated public health and law enforcement investigators and
  2. Immediate family members designated by the local health department in collaboration with hospital staff, who have already had “close contact” with the suspect case after the onset of his/her rash and prior to hospitalization.
  3. All staff and designated family members, prior to entering the room, are to be instructed in the meaning of contact, airborne and standard precautions.
    - a. All hospital staff (*including transport personnel*) and visitors must don contact and airborne personal protection and eye protection, if within 3 (three) feet of a coughing suspect case (*i.e., disposable gloves, eye protection, gowns, and an N-95 or higher respirator*) regardless of their prior smallpox vaccination status.
    - b. Non-healthcare individuals, entering the room, must have assistance in selecting appropriate personal protective equipment.
    - c. All hospital, public health and law enforcement staff will have undergone fit-testing for appropriate respiratory protection.
    - d. As per standard precautions, eye protection or a face shield to protect mucous membranes of the eyes are to be worn for all procedures or patient care activities that are likely to generate splashes or sprays of blood, body fluids, secretions or excretions (*e.g., respiratory suctioning*).
    - e. Preferably only persons who are “vaccine eligible” are to be allowed in the suspect case room.
    - f. A staff person is to be stationed outside the suspect case room at all times to ensure adherence to all the above protocols.

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- g. Information on all persons, who enter the room, is to be kept in a logbook outside the suspect case's room.
    - 1) Specifically, the names and job duty (*for hospital staff*) are to be recorded. Non-hospital staff and visitors are to provide names, work location, work phone number, home phone number, cellular phone number, and beeper numbers on the logbook. (See **Log of Close Contacts, page 17**).
    - 2) The log is to be used for tracking all "close contacts". This information will be used by the local health department to ensure that all persons, who have had "close contact" with the suspect case, are prioritized for immediate vaccination in the event that smallpox is confirmed.
  - h. Any non-vaccinated person, entering the suspect case room, will be vaccinated as soon as the suspect case is confirmed. If the suspect case cannot be confirmed within three days, all persons in "close contact" with the suspect case will be vaccinated.
- G. The hospital is to ensure that the following additional infection control precautions are adhered to:
- 1. Disposable items are to be used whenever possible.
  - 2. After use, all disposable personal protective equipment is to be placed into a plastic biohazard bag and left in the suspect case room (*gowns, gloves*) or outside of the room (*respirators*). Ideally, these are to be placed in the anteroom, if a AII with anteroom is available. N-95 respirators should not be re-used; if positive air pressure respirators (PAPR) are used, the PAPR should be cleaned and disinfected prior to entering another patient's room.
  - 3. As much as possible, dedicated patient care equipment (*e.g., blood pressure cuffs and stethoscopes*) is to be used for care of the suspect case and left in the patient's room. If equipment must be used on other patients (*e.g., portable X-ray machine*), all equipment must be cleaned and disinfected with EPA-registered hospital disinfectants (*e.g., quaternary ammonium compounds*) or sodium hypochlorite (*1:10 dilution of household bleach*).
    - a. The Medical Record is to be kept outside the room of the suspect case so as to prevent contamination of the Medical Record.
    - b. All non-essential equipment and supplies are to be removed from the room of the suspect case before the suspect case is admitted to the room.
    - c. Staff and others entering the room of the suspect case should keep any equipment and supplies (*e.g. phlebotomy*) to the minimum necessary.

## Wisconsin Public Health Emergency Plan

4. All non-sharps waste is to be disposed in impervious biohazard bags of adequate strength; otherwise, they are to be placed in a second biohazard bag for disposal or transported for incineration or for other approved disposal methods. Since the laboratory test results for a **moderate** to **high risk** patient should be available within 24-48 hours after specimens are collected, hospitals, if possible, are to keep all biohazard waste bags in the suspect case room until smallpox has been ruled out. If smallpox is ruled out, waste can be disposed of according to standard waste disposal protocols.

If smallpox is confirmed, this waste is to be incinerated.

5. Disposable trays and utensils should be used. All food scraps should be bagged and kept in the suspect case room while awaiting confirmation. This waste is then to be disposed of in the same manner as mentioned in # 4 above (incinerated if smallpox is confirmed; ordinary disposal if smallpox is ruled out).
6. All used laundry and linens are to be handled carefully to prevent aerosolization or direct contact with potentially infectious material. Anyone directly handling the suspect case's linen or laundry is to wear a gown, gloves and a respirator (N-95 or higher). Laundry and linens are to be placed in biohazard bags of adequate strength; otherwise, they are to be double-bagged and are to remain in the room in a covered hamper until laboratory results are available.

### H. The suspect case is to be kept in his/her room except for medically essential procedures that cannot be done at the bedside.

1. Any movement of the suspect case outside of the room of the suspect case should only be done in consultation with Infection Control staff.
2. If the suspect case needs to be transported, the security of the suspect case room must be maintained.
3. To minimize the potential for contamination when transported outside of the "AII", a surgical mask is to be placed on the suspect case. Active skin lesions must be completely covered. A sheet is to be used to cover their skin as much as possible; the linens are to be tucked under the stretcher to manipulation of the linens to protect against aerosolization of any potentially infectious material. All staff are to wear a gown, gloves and a respirator (*fit-tested N-95 or higher*) even when the suspect case is covered and wearing the surgical mask.
4. If staff involved in transporting the suspect case have direct contact with the suspect case (*e.g., contact with skin or oral secretions*) when moving the suspect case from his/her bed to the stretcher or wheel chair, their gowns and gloves may be contaminated.

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- a. Prior to leaving the suspect case's room, staff are to remove their personal protective equipment and don clean protective gear.
- b. Unnecessary equipment in the room should be removed or protected from inadvertent contamination (e.g. covered with a plastic sheet or drape).
- c. The department receiving the patient for the medical procedure (e.g., *radiology or surgery*) are to be notified prior to transport so that appropriate arrangements can be made for direct and immediate access to the procedure room.
- d. The infection control precautions outlined above are to be followed by all hospital staff involved in the care of the suspect case while he/she is undergoing medical procedures outside of the negative pressure airborne isolation room.
- e. Transport equipment (e.g., *stretcher or wheelchair*) or equipment in the procedure room (e.g., *x-ray table*) is to be cleaned with EPA-registered hospital disinfectants (e.g., *quaternary ammonium compounds*) or sodium hypochlorite (*1:10 dilution of household bleach*).
- f. All waste, linens, etc. from the suspect case are to be placed in biohazard bags of adequate strength; otherwise, they are to be double-bagged and stored in the suspect case room. Sharps, used on the suspect case, are to be placed in the sharps container, which is to be placed in biohazard bags of adequate strength; otherwise, they are to be double-bagged and stored in the suspect case room.
- g. The logbook is to accompany the suspect case and all staff, who have contact with the suspect case, should complete the information in the logbook. Care is to be taken not to contaminate the logbook.
- h. All non-vaccinated staff, who participate in any procedure that takes place outside the suspect case room, are to be vaccinated as soon as the suspect case is confirmed or if the case is still in doubt after three days.
- i. Care is to be taken when handling routine clinical laboratory specimens. Laboratory requests are to be limited to those tests that are essential to patient management. All clinical specimens are to be placed in double, zip-locked bags that are tightly sealed and properly labeled prior to transport to the laboratory.
  1. Specimens are to be hand-carried to the laboratory and pneumatic tube systems are not to be used.

2. Laboratorians are to be trained in handling clinical specimens and understand that the risk of smallpox infection due to contact with samples for a suspect case is low when handled appropriately.

NOTE: An exception will be laboratory tests involving the skin lesions themselves (*e.g., DFA testing for varicella*) where ideally only pre-vaccinated laboratory staff are to be handling the specimens).

3. Non-vaccinated laboratory staff are to be vaccinated if they have handled the suspect case specimens and if the suspect case is confirmed or if the suspect case is still in doubt after three days.

#### IV. Management of the Emergency Department or Clinical area, Pending Evaluation and Laboratory Test Results:

The following guidelines apply to the Emergency Department or clinical area where the **moderate** or **high-risk** patient was initially evaluated and may have spent time prior to being placed in a negative pressure airborne isolation room.

No additional steps are needed for management of the Emergency Department or clinical area, if the patient is deemed to be at **low risk** for smallpox, unless indicated based on the patient's diagnosis (*e.g., measles*)

After notification of the local health department regarding a **moderate** or **high risk** patient and the local health department concurs that the individual is at **moderate** or **high risk** for smallpox, the following actions will be taken while awaiting arrival of the local health department evaluation and/or laboratory determination of whether or not the suspect case has smallpox:

##### A. Management of "Close Contacts":

1. All persons, including visitors and other patients (*as long as medically stable*), in the Emergency Department, clinical area or other areas of the hospital who had "close contact" with the suspect **moderate** or **high risk** patient before he/she was placed in a negative pressure airborne isolation room are to be moved to a separate room apart from the Emergency Department or clinical area.
2. These "close contacts" are to be detained in the separate room and their information entered into the log (see log of close contacts, page 17). No "close contact" is permitted to leave the room nor are any other persons to be allowed to enter the room, unless authorized by the hospital or the local health department.
3. Infection control or other appropriate hospital staff are to start a log sheet (see log of close contacts, page 17), tracking all "close contacts" of the suspect **moderate**

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or **high risk** case prior to his/her being placed in a negative pressure airborne isolation room to share with the local health department staff when they arrive.

- a. The names, home addresses, and 24-hour contact information (*including home and work telephone, cellular phone, and beepers*) are to be noted for all “close contacts”.
  - b. If the suspect case visited another part of the hospital (*cafeteria*) or was transported to another location during their evaluation (*e.g. radiology*) prior to being placed in a negative pressure airborne isolation room and under airborne and contact precautions, the contact tracking should be extended to these additional areas. “Close contacts” are to be vaccinated if the case is confirmed or if the case is still in doubt after three days.
4. As it may take time for the local health department to arrive on-site, the hospital staff should pre-designate infection control or other appropriate staff person(s) to begin to counsel these patients and visitors.
- a. Prepared fact sheets for use in educating persons who were potentially exposed to smallpox about their risk and what steps the local health department will take in the event that smallpox is confirmed are included in: **Information for People Who May Have Been Exposed To Smallpox, page 18**; hospitals are to have copies ready to distribute to potential “close contacts” to read while awaiting the arrival of the local health department staff.
5. The local health department is to send staff to interview and counsel all “close contacts” (*including emergency department and clinic staff, other patients, and visitors*), as well as review the educational materials and provide a 24-hour local health department telephone hotline number for all contacts to use if they have additional questions or concerns after leaving the hospital.
- a. Local health department staff will interview all “close contacts” of **moderate** or **high risk** patients and ensure that emergency contact information has been obtained in the event that the suspect case is confirmed as smallpox, so that these persons can be immediately called with instructions on where and when to receive smallpox vaccination.
6. Hospital staff are to ensure that all “close contacts” of suspect **moderate** or **high** risk cases remain in the hospital until the local health department staff arrive:
- a. For “close contacts” of **moderate risk** patients: If “close contacts” of **moderate risk** patients refuse to wait until the local health department staff arrive, the hospital is to reiterate the importance of staying and if they are

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unable to convince the person(s) to stay, the hospital must obtain contact information *prior* to the “close contact” leaving the hospital.

- b. For “close contacts” of **high risk** patients: If the preliminary assessment by the local health department at the time of the initial telephone consultation is that the suspect case may be at **high risk** for smallpox, the local health department may order the hospital to hold all “close contacts” in a separate waiting area until local health department staff arrive.
  - 1) The decision to order Emergency Department or clinic “close contacts” to be held will be based on the circumstances of the event.
  - 2) At the time that the decision is made to hold the “close contacts” in the Emergency Department or clinic during the initial telephone consultation, the local health department will fax to the hospital an Order, requiring the holding of the “close contacts”, until such time as the local health department staff arrive to interview and counsel these individuals.
  - 3) If the hospital requires assistance to detain these persons, the local health department will contact the law enforcement to advise them of the situation and to request that officers be sent to the hospital to assist in holding the “close contacts”.
  - 4) Any patient, who is medically unstable or not able to be moved, is to be cared for in the Emergency Department or clinical area. It is not necessary for the Emergency Department or clinical area staff contacts to be held in this same room as long as these staff are available for interviews when the local health department staff arrive.

### B. Cleaning Any Area Occupied by a Suspect Case

1. Any area, occupied by a suspect case, is to be quarantined until it is cleaned.
2. All equipment and surfaces, including such items as cubicle curtains, carpeting and upholstered items are to be cleaned as per contact isolation protocols with standard EPA-registered hospital disinfectants (*e.g., quaternary ammonium compounds*) or sodium hypochlorite (*1:10 dilution of household bleach*) if smallpox is confirmed or highly suspect.
3. After discussion with the local health department, the Emergency Department or waiting area or other areas, occupied by the suspect case can be re-occupied after
  - a. It has been cleaned with EPA-registered hospital disinfectants (*e.g., quaternary ammonium compounds*) or sodium hypochlorite (*1:10 dilution of household bleach*) and



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- b. An appropriate period of time has elapsed to ensure room clearance, based on the ability of the *affected hospital areas' HVAC system to achieve 6 - 12 air exchanges*. (See *Guidelines for Preventing the Transmission of Mycobacterium tuberculosis in Health-Care facilities. MMWR 1994; 43 (R-13):page 72*).
  - c. Facilities engineers are to identify air exchange rates for each room/area in the hospital and use the table to post the air exchange rates.
  - d. Individuals in areas receiving potentially contaminated recirculated Emergency Department air are to be tracked as “close contacts”. Once the suspect case is appropriately isolated, an appropriate period of time is to elapse to ensure room clearance, based on 6 - 12 air exchanges in the affected area.
4. The housekeeping staff involved in cleaning these areas is to be limited to persons who are confirmed vaccinated or “preferably vaccine eligible”. While cleaning the area, these staff are to use appropriate personal protective equipment (*i.e., disposable gloves, shoe covers and gowns and fit-tested N-95 or higher level of respiratory protection*).
- C. Decision Regarding Whether the Emergency Department or Clinical area Should be “Quarantined” or Whether the Hospital Should Consider Temporary “Termination of Services”:
- 1. There is no need to quarantine the hospital, Emergency Department, or clinical area or to consider diversion of patients if
    - a. the suspect case was masked when entering the hospital building
    - b. the suspect case was admitted directly to a negative pressure airborne isolation room
  - 2. Quarantine of the hospital or any area of the hospital and diversion of patients is to be considered only in consultation with hospital administrative staff, infectious disease and infection control staff and the local health department.

### **Guidelines for Assessing Vesicular and Pustular Rashes**

(Adapted from the CDC Poster or “Evaluating Patients for Smallpox”)

The following risk assessment should be considered when evaluating a patient with a vesicular or pustular rash to determine the likelihood of smallpox:

**High Risk of Smallpox - All 3 of the following criteria must be present:**

- a) Febrile prodrome – Occurring 1-4 days before rash onset with fever > 101°F and at least one of the following: prostration, headache, backache, chills, vomiting or severe abdominal pain, **and**
- b) Classic smallpox lesions – Deep-seated, firm/hard, round well-circumscribed vesicles or pustules; as they evolve, lesions may become umbilicated or confluent, **and**
- c) Lesions in same stage of development – On any one part of the body (*e.g., the face or arm*) all the lesions are in the same stage of development (*i.e., all lesions are vesicles or all are pustules*)

**Moderate Risk of Smallpox:**

- a) Febrile prodrome – Occurring 1-4 days before rash onset with fever > 101° F and at least one of the following: prostration, headache, backache, chills, vomiting or severe abdominal pain, **and either**
  - 1) Classic smallpox lesions – Deep-seated, firm/hard, round well-circumscribed vesicles or pustules; as they evolve, lesions may become umbilicated or confluent, **or**
  - 2) Lesions in same stage of development – On any one part of the body (*e.g. face or arm*) all the lesions are in the same stage of development (*i.e., all lesions are vesicles or all are pustules*) **OR**
- b) Febrile prodrome – Occurring 1-4 days before rash onset with fever > 101° F and at least one of the following: prostration, headache, backache, chills, vomiting or severe abdominal pain, **and FOUR or more of the following MINOR criteria:**
  - 1) Centrifugal distribution: greatest distribution of lesions on the face and distal extremities
  - 2) Initial lesions occur on the oral mucosa/palate, face or forearm
  - 3) Patient appears toxic or moribund
  - 4) Lesions exhibit a slow evolution – evolving from macules to papules and then to pustules over days (each stage lasts 1-2 days)
  - 5) Lesions on the palms and soles

**Low Risk of Smallpox:**

- a) No febrile prodrome, **OR**
- b) Febrile prodrome – Occurring 1-4 days before rash onset with fever  $> 101^{\circ}$  F and at least one of the following: prostration, headache, backache, chills, vomiting or severe abdominal pain, but **LESS THAN FOUR of the following MINOR criteria:**
  - 1) Centrifugal distribution: greatest distribution of lesions on the face and distal extremities
  - 2) Initial lesions occur on the oral mucosa/palate, face or forearm
  - 3) Patient appears toxic or moribund
  - 4) Lesions exhibit a slow evolution – evolving from macules to papules and then to pustules over days (each stage lasts 1-2 days)
  - 5) Lesions on the palms and soles

**Differentiation of Chickenpox from Smallpox**

Chickenpox (varicella) is the most likely condition to be confused with smallpox. In chickenpox, the following findings on history and physical examination are usually found:

- a) No or mild prodrome
- b) Lesions are superficial vesicles (“dewdrops on a rose petal”)
- c) Lesions appear in crops; on any one part of the body, there are lesions in different stages (*papules, vesicles, pustules, crusted lesions*)
- d) Centripetal distribution: greatest concentration of the lesions on the trunk, fewest lesions on the distal extremities. May involve the face and scalp. Occasionally, the entire body is equally affected
- e) First lesions appear on the face or trunk
- f) Patients are rarely toxic or moribund
- g) Lesions progress through a rapid evolution from macules to papules to vesicles to crusted lesions (< 24 hours)

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- h) Palms and soles rarely involved
- i) Patient lacks reliable history of either varicella infection or vaccination
- j) 50-80% of patients recall a recent exposure to chickenpox or shingles within the 10-21 days before the onset of their rash

The full protocol with color photographs of smallpox and varicella skin lesions is available as a poster (“Evaluating Patients for Smallpox -Acute, Generalized Vesicular and Pustular Rash Illness Protocol”). Copies of this poster can be obtained through the CDC website at <http://www.bt.cdc.gov/agent/smallpox/diagnosis/pdf/spox-poster-full.pdf>

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## Log of Close Contacts

[illegible]

\* Describe the role of the close contact, e.g. staff, visitor, public health, law enforcement, visitor, etc.

\*\* Describe the time of Contact: “P” for prior to isolation of suspected case; “A” for after isolation of suspected case

## **Information for People Who May Have Been Exposed To Smallpox**

Your local health department is working with the hospital to find out if a patient in this hospital has a smallpox infection. Since you may have been in the same area as this patient, we wanted to let you know

- (a) what we are doing to find out if this patient has smallpox and
- (b) how we will try to prevent you from getting smallpox, if we find out that you may have been exposed to someone who does have smallpox.

We understand how worried you may be. If this turns out to be smallpox, a smallpox vaccine (or “shot”), given within 4 days of exposure, can prevent this disease or lessen the seriousness of the illness. Local health department staff will be available to answer your questions in person.

### **What is smallpox?**

Smallpox is a very serious viral infection that was eradicated from the world in 1977 after a successful vaccine campaign by the World Health Organization.

### **What are the chances that a patient in this hospital has smallpox?**

Today, there is no naturally occurring smallpox in the world. However, there are concerns that some countries, which sponsor terrorism or terrorist groups, may have the- smallpox virus and may use it during war or a terrorist attack. At this time, we have no information indicating that a bioterrorism attack has taken place. However, we want to make absolutely sure that the patient in this hospital does not have smallpox. Therefore, the local health department is arranging special laboratory testing to be sure that this is not smallpox.

### **How long will it take before the laboratory tests are ready?**

The local health department is working very closely with the hospital staff, to arrange laboratory testing for this patient. Smallpox testing is only available at the Centers for Disease Control and Prevention (CDC) in Atlanta, Georgia. The local health department is arranging an emergency flight to take the patient’s laboratory samples to the CDC for testing. Test results should be available within 24-48 hours after the laboratory samples arrive at the CDC.

### **How is smallpox diagnosed?**

Smallpox is diagnosed by looking for evidence of the virus in tissue samples as well as by growing the virus in the laboratory. These tests can- only be done at the CDC in Atlanta.

### **How is smallpox spread?**

Smallpox is spread person-to-person. Persons who have been in proximity (*in the same room*) with someone who has smallpox are called “close contacts” and may be at risk for developing smallpox. Smallpox is more likely to be spread through contact with the patient or if the patient is coughing. The risk is greatest for persons who spent more time with the patient (*for example, persons who live in the same house*) compared to persons who were only in the same room for shorter periods of time (*for example, persons who shared the same waiting room*).

**If you were exposed to smallpox, how long before you get sick and what are the symptoms?**

Symptoms usually start 12 to 14 days after infection with smallpox. Symptoms include high fever, severe body aches, vomiting, and a distinctive rash. This rash may appear 2 to 3 days after the start of the fever and will usually start on the face, hands, forearms, and palms and soles. It then quickly spreads to the legs and then the trunk after about two weeks.

**Are you contagious now? If you go home, will your family be at risk?**

No, you are not contagious now. We still do not know if the patient at this hospital has smallpox. In the event that this is smallpox and you were exposed and get sick, you would not be contagious for one week or longer. You would not be contagious until you develop the rash. Smallpox vaccine can prevent infection from occurring, even if given up to 4 days after exposure. We should know within 48 hours whether the patient at this hospital does have smallpox.

**What is the treatment for smallpox?**

Although there is no known effective treatment for the disease once symptoms occur, a vaccine given within four days of exposure can prevent infection. In addition to providing protection, the vaccine against smallpox can also stop the spread of this disease. If there is a smallpox case or outbreak, the CDC has developed guidelines to quickly provide vaccine to people exposed to the disease. The vaccine is stored by CDC and is for emergency use only.

**How will you be protected against smallpox?**

In most cases, smallpox vaccine, if given within 4 days of exposure, can prevent you from becoming infected or seriously ill. We should have the laboratory test results within the next 24-48 hours. If smallpox is confirmed, the CDC can bring the smallpox vaccine supplies to us within a few hours and the local health department will be sure that you are offered this vaccine to prevent you from getting sick with smallpox.

**Why can't you get the smallpox vaccine now?**

The smallpox vaccine is a live virus and can cause severe side effects, such as encephalitis (*inflammation of the brain tissues*) and even death, in a small number of persons who receive the vaccine. Therefore, we do not want to vaccinate you until we

are sure that the patient you may have been exposed to has smallpox. The vaccine can prevent you from getting sick if you are vaccinated up to 4 days after being exposed and we should have the laboratory results within 24-48 hours. .

**Why do you have to wait to be interviewed by the local health department?**

The local health department staff are interviewing all persons who were in “close contact” with this patient, to make sure we know how to reach you in case smallpox is confirmed and we need to arrange for you to receive the smallpox vaccine. It is very important that we have detailed information on how we can reach you 24 hours a day (*your home and work phone, your cell phone and your pager*), so that we can call you immediately with the test results and tell you where to go, in case you need to get the smallpox vaccine.

**Instructions for Smallpox Patients on Home Care  
(name and contact info for LHD)**

**If you have smallpox and are being cared for at home:**

- Follow the instructions your doctor gave you.
- Do not leave your home or area of isolation until all scabs have fallen off, AND you have been cleared to do so by your local health department.
- If possible, wear a surgical mask when you are around other people in the home. If you cannot wear a mask, others around you should wear a surgical mask when they are near you.
- Don't share dishes, drinking cups, silverware, towels or bedding with anyone else until they have been washed with soap and hot water.

**If you are taking care of someone at home who has smallpox:**

- All non-vaccinated persons should be housed elsewhere until they are vaccinated and have a “take” that indicates immunity.
- Do not allow unauthorized persons into the home or area of isolation. Only persons authorized by the local health department should enter the isolation area.
- Make sure the person with smallpox has seen a health-care provider and is following instructions for medication and care.
- Make sure all members of your household are washing their hands frequently with soap and warm water or using alcohol-based hand wash.
- Wear disposable gloves and gown if you have direct contact with a smallpox patient, lesions, body fluids, or contact with contaminated items. However, the wearing of gloves is not a substitute for good hand hygiene. Wash hands immediately after removing gloves and gown.
- If possible, the person with smallpox should wear a surgical mask during close contact with other people in the home. If the patient cannot wear a surgical mask, other members of the household should wear one when in the room with that person.



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- Do not use silverware, towels, bedding, clothing, or other items that have been used by the person with smallpox until these items have been washed with soap and hot water.
- Clean surfaces (counter or tabletops, doorknobs, bathroom fixtures, etc.) that have been contaminated by body fluids (sweat, saliva, mucous, or even vomit or urine). Use a household disinfectant such as Lysol™ or bleach according to the directions on the label. Wear disposable gloves during all cleaning activities. Discard gloves after use.
- Follow these precautions until all scabs have fallen off the patient AND the local health department has determined that the patient is no longer infectious.
- Disposable items that have been contaminated by the patient should be sealed in a zip-lock bag and then placed in a second trash bag for disposal into regular trash.

Attachment 5

## Infection Control Guidelines for Suspect Cases of SARS

### I. Introduction

Severe acute respiratory syndrome (SARS) is a new disease that initially emerged in Asia, North America, and Europe in the spring of 2003. SARS appears to be transmitted primarily by large droplets spread during close person-to-person contact. But the possibility of airborne transmission cannot be ruled out, thus infection control measures in health care facilities should include both airborne and contact precautions.

The purpose of airborne and contact precautions is to reduce the risk of transmission of disease while continuing to provide quality patient care.

### II. Definitions

#### A. Case Definitions

A “**case**” means a person determined to have a particular communicable disease on the basis of clinical or laboratory criteria or both. HFS145.03 (2)

A “**suspect case**” means a person thought to have a particular communicable disease on the basis of clinical or laboratory testing. HFS145.03 (27)

**See SARS case definitions on page 14.**

#### B. Other Definitions

A “**close contact**” is someone who has cared for or lived with a person known to have SARS or has a high likelihood of having direct contact with respiratory secretions and/or body fluids of a patient known to have SARS. Examples of close contact include kissing, embracing, sharing of eating or drinking utensils, close conversation (within 3 feet), physical examination, and any other direct physical contact between persons. Close contact does not include activities such as walking by a person or sitting across a waiting room or office for brief periods of time.

“**Isolation rooms**” are defined as airborne infection isolation (AII) rooms that have a minimum of 6-12 air exchanges per hour (ACH) and direct exhaust to the outside, which is located more than 25 feet from an air intake and from areas where people may pass. If air cannot be exhausted directly to the outside more than 25 feet from an air intake and from areas where people may pass, then air should be filtered through an appropriately installed and maintained HEPA filter. These rooms should be tested monthly (and daily

when in use) to verify negative airflow. Current rooms may have 6 ACH but newly constructed or renovated rooms must have a minimum of 12 ACH.

Note: If rooms in older facilities must be “switched on” to provide 6- 12 air exchanges per hour, then a method must be implemented to ensure that this occurs and is monitored.

**“Pre-identified room”:** In hospitals that do not have “AII” that meet the above criteria, an enclosed private room(s) should be pre-identified for “isolating” patients with fever and respiratory symptoms to minimize exposure to other patients and staff (*e.g., an examination room at the end of a hallway*). A transportation route from the Emergency Department to this preidentified room also is to be established.

### III. Initial Management of Patients with Respiratory Illnesses

Consider placing signs at the entrance of the Emergency Department, instructing persons with respiratory symptoms to practice “respiratory hygiene,” i.e. cover nose and mouth with tissue when coughing or sneezing, discarding tissue, then washing hands with soap and water or using alcohol hand sanitizer.

Patient transport staff should notify the Emergency Department in advance if transporting patients with fever and respiratory symptoms.

Any patient presenting for evaluation in the Emergency Department with fever and respiratory symptoms will be immediately masked and placed in isolation.

- If no known SARS transmission is occurring in the world, patients will be placed in droplet isolation.
- If SARS transmission has been identified anywhere in the world, patients will be placed in isolation according to CDC recommendation that are based on the current world situation.

#### A. Recognition of a Suspect Case When No SARS Cases are Occurring

1. In the absence of SARS cases in the world, screen all hospitalized patients with chest x-ray confirmed pneumonia or acute respiratory distress syndrome, when etiology is unknown, for the three following characteristics that might indicate a higher index of suspicion for SARS:
  - In the ten days before illness onset, travel to or close contact with other ill persons who recently traveled to a previously affected SARS area.
  - Employment as a health care worker with direct patient contact.
  - Close contact with someone recently found to have radiographic evidence of pneumonia of unknown etiology.

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2. If any one of the above conditions exists, place the patient in standard and droplet precautions and contact the local health department.
3. Infection control practitioners and other appropriate health care personnel should be alert for cases of unexplained pneumonia among two or more health care workers who work in the same facility. Report such cases to the local health department.

### B. Recognition of a Suspect Cases When SARS is Occurring

1. Once SARS transmission has been identified anywhere in the world, all patients with respiratory symptoms who are seen in the health care facility should be screened for risk of SARS.
2. Place patients in the appropriate isolation precautions based on the outcome of the assessment.
3. Clinical Assessment of Patients

Refer to the CDC website

<http://www.cdc.gov/ncidod/sars/clinicalguidance.htm> for an algorithm with complete details on clinical assessment of patients. Below is only a summary of assessment steps.

Clinical assessment of patients with respiratory illnesses will depend on the presence or absence of SARS cases in the world.

The following protocol for evaluation of patients hospitalized with radiographic evidence of pneumonia should be used when SARS activity worldwide is absent.

1. Evaluate for alternative diagnosis, which may include the following:
  - a. CBC with differential
  - b. Pulse oximetry
  - c. Blood cultures
  - d. Sputum Gram's stain and culture
  - e. Tests for viral respiratory pathogens such as influenza and RSV
2. After 72 hours, if an alternate diagnosis has been found, treat and isolate according to the causative agent.
3. If an alternate diagnosis has not been found after 72 hours, and there are other reasons to suspect SARS, consider SARS testing in consultation with the state health department.

4. If SARS testing is determined necessary, place patient in standard, airborne, and contact isolation, and use eye protection for every patient contact.

The following protocol for evaluation of patients with fever or respiratory symptoms should be used when SARS activity has been detected anywhere in the world.

1. If the patient has had recent close contact with persons suspected to have SARS or exposure to locations where SARS transmission is suspected, initiate a preliminary work up and notify the state health department.
2. Perform SARS testing (in consultation with state health department) if there is radiographic evidence of pulmonary infiltrates.
3. Consult algorithm for further steps in case assessment and recommended isolation precautions.

#### **IV. Management of Suspect, Probable, and Confirmed SARS Cases**

##### **A. Isolation**

1. Suspect SARS cases should be placed on airborne and contact precautions upon entrance to the facility.
2. It is recommended that the inpatient AII have a toilet, sink, and a bath or shower.
3. If AII rooms are NOT available, place patients in private rooms. Hospital personnel should wear fit-tested N-95 respirators when entering the rooms. If N-95 respirators are not available, health care workers evaluating and caring for SARS cases should wear a surgical mask.
4. Infection control personnel should be notified immediately of suspect SARS cases. They in turn will notify the local health department. If not already involved, consultations are to be requested from infectious disease specialists.
5. Signs noting the need for airborne and contact precautions are to be displayed outside isolation rooms. Doors to isolation rooms should be kept closed (self-closing doors are preferable).

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6. Eye protection is to be worn during contact with all suspect SARS cases.  
*(Note: Eye protection should protect the eyes from splashes from above or from the sides of the eyes.)*
7. If available, the suspect case is to be placed in “AII” with an anteroom that has a sink, so that persons leaving the room can dispose of their protective clothing and equipment and wash their hands before exiting to the hallway.
8. In the absence of an anteroom, gowns and gloves are to be removed inside the suspect case room and discarded in a waste receptacle just inside the room by the door. A separate waste receptacle is to be placed immediately outside the suspect case room for disposal of used respirators.

### B. Traffic in Isolation Rooms

1. The number of persons entering isolation rooms should be minimized as much as possible. Visitors should be limited to:
  - a. Designated public health officials.
  - b. Designated family members, determined by the local health department.
2. All staff and designated family members, prior to entering the room, are to be instructed in the meaning of contact, airborne and standard precautions.
  - a. Designated visitors must wear contact and airborne personal protection and eye protection when entering rooms of suspect cases, and should be offered assistance if needed.
  - b. All hospital and public health staff will have undergone fit testing for appropriate respiratory protection.
  - c. Information on all persons who had unprotected exposure to a suspect SARS case is to be kept in a logbook outside the isolation room. The names and job duty (*for hospital staff*) are to be recorded. Non-hospital staff and visitors are to provide names, work location, work phone number, home phone number, cellular phone number, and beeper numbers on the logbook. All information should be given to the local health department for purposes of contact tracing.

### C. Patient Care Items and Equipment

1. Disposable items are to be used whenever possible.

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2. After use, all disposable personal protective equipment is to be placed into regular trash in the isolation room (*gowns, gloves*) or outside of the room (*respirators*). Ideally, these are to be placed in the anteroom, if an AII with anteroom is available. N-95 respirators should not be re-used unless in short supply. If re-used, employ the following protocol: Wear a face shield or surgical mask over the respirator. Dispose of the surgical mask, or clean and disinfect the face shield after use. Remove the respirator, place in plastic bag, and hang in designated area.
3. As much as possible, dedicated patient care equipment (*e.g., blood pressure cuffs and stethoscopes*) is to be used for care of the suspect case and left in the patient's room. If equipment must be used on other patients (*e.g., portable X-ray machine*), all equipment must be cleaned and disinfected with EPA-registered hospital approved disinfectants (*e.g., quaternary ammonium compounds*)
  - a. The medical record is to be kept outside the room of the suspect case to prevent contamination. Maintain privacy of the medical record.
  - b. All non-essential equipment and supplies are to be removed from the room or protected from contamination (*e.g. plastic sheet or drape*) before the suspect case is admitted to the room.
  - c. Staff and others entering the room of the suspect case should keep any equipment and supplies (*e.g. phlebotomy*) to the minimum necessary.
  - d. It is not necessary to use disposable eating utensils, trays, or dishes for suspect SARS cases.

### D. Patient Transport

1. The suspect case is to be kept in the isolation room except for medically essential procedures that cannot be done at the bedside.
2. Any movement of the suspect case outside of the isolation room should be done only in consultation with infection control staff.
3. If the suspect case needs to be transported, staff should ensure that no unauthorized persons enter the room while unoccupied.
4. To minimize the potential for contamination when transported outside of the "AII", a surgical mask is to be placed on the suspect case.
5. If staff involved in transporting the suspect case have direct contact with the suspect case (*e.g., contact with skin or oral secretions*) when moving the suspect case from his/her bed to the stretcher or wheel chair, their gowns and gloves may be contaminated.

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- a. Prior to leaving the isolation room, staff should remove their personal protective equipment. All items should be decontaminated before leaving patient room. This includes beds or wheelchairs used for transport. Transport staff should consist of two persons, one to have patient contact, if necessary, and the other to handle the bed, wheelchair, doors, and other items in the environment without contaminating them.
- b. The department receiving the patient for the medical procedure (*e.g., radiology or surgery*) are to be notified prior to transport so that appropriate arrangements can be made for direct and immediate access to the procedure room.
- c. The infection control precautions outlined above are to be followed by all hospital staff involved in the care of the suspect case while he/she is undergoing medical procedures outside of the negative pressure airborne isolation room.
- d. Transport equipment (*e.g., stretcher or wheelchair*) or equipment in the procedure room (*e.g., x-ray table*) is to be cleaned with EPA-registered hospital approved disinfectants (*e.g., quaternary ammonium compounds*) or sodium hypochlorite (*1:10 dilution of household bleach*).
- e. No one else should be present on elevators used for transport except the patient and transport staff.

### E. Aerosol-Generating Procedures

Aerosol-generating procedures may increase the risk of SARS transmission. Health care workers present during such procedures should observe special precautions. See page 18 for infection control precautions during aerosol-generating procedures.

### F. Laundry and Linens

1. Staff should handle all laundry and used linens carefully to avoid contact with potentially infectious material.
2. Anyone handling used linen or laundry should wear a gown and gloves.

### G. Environmental Cleaning/Disinfection

1. Inpatient isolation rooms should be cleaned and disinfected daily and at time of transfer or discharge.



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2. All equipment and surfaces, including such items as cubicle curtains, carpeting and upholstered items are to be cleaned according to contact isolation protocols with standard EPA-registered hospital disinfectants (e.g., *quaternary ammonium compounds*).
3. Before initiation of terminal cleaning and disinfecting of AII rooms, allow an appropriate period of time to elapse to ensure particulate removal, based on the ability of the affected hospital area HVAC system to achieve 6 to 12 air exchanges. (*Guidelines for Preventing the Transmission of Mycobacterium tuberculosis in Health-Care facilities. MMWR 1994; 43 (R-13):page 72*). **Note:** The facility engineers should identify air exchange rates for each room/area in the hospital and post the air exchange rates based on the table in the guidelines.
4. Staff involved in cleaning and disinfection activities should wear full protective attire as required by contact isolation (disposable gowns, utility gloves). Fit-tested N-95 respirators and eye protection (face shields or goggles) should be worn while patients are in the rooms.
5. Solutions used for cleaning and disinfection should be discarded after being used in a SARS isolation room. Also thoroughly rinse and clean housekeeping equipment after use. Launder reusable mop heads and cleaning cloths according to current practice.

### H. Laboratory Specimens

Care is to be taken when handling routine clinical laboratory specimens.

1. Laboratory requests are to be limited to those tests that are essential to patient management.
2. Laboratory staff should be trained in handling clinical specimens to understand that the risk of SARS infection due to contact with samples for a suspect case is low when handled appropriately.
3. All clinical specimens are to be placed in zip-lock bags that are tightly sealed and properly labeled prior to transport to the laboratory.
4. Labels on the specimens should indicate the need for special handling by laboratory staff (e.g., “use precautions for aerosol-generating procedures”).
5. Blood and urine specimens can be handled in the laboratory using standard precautions.

6. Refer to the following website for details on safe handling of laboratory specimens: <http://www.cdc.gov/ncidod/sars/sarslabguide.htm>.

**I. Removal of Personal Protective Equipment (PPE)**

1. Disposable PPE is recommended for use whenever possible to allow for more convenient removal.
2. See page 20 for suggested method of PPE removal when using disposable PPE.

**J. Discontinuation of Isolation/Discharge of Cases**

1. Health care staff should notify the local health department when patients are ready for discharge. The local health department will make arrangements for appropriate post-discharge isolation or quarantine of SARS cases.
2. Patients may be removed from isolation 10 days after the time when their fever resolves and respiratory symptoms are absent or improving.

**V. Management of Close Contacts of Suspect SARS Cases**

A close contact is defined as having cared for or lived with a person known to have SARS or having a high likelihood of direct contact with respiratory secretions and/or body fluids of a patient known to have SARS. Examples of close contact include kissing or embracing, sharing eating or drinking utensils, close conversation (<3 feet), physical examination, and any other direct physical contact between persons. Close contact does not include activities such as walking by a person or sitting across a waiting room or office for a brief period of time.

Quarantine of the hospital or any area of the hospital and diversion of patients is to be considered only in consultation with hospital administrative staff, infectious disease and infection control staff and the local health department.

**A. Role of Local Health Department Staff**

1. Any decisions to quarantine close contacts must be made by the local health department. Local health departments will make the necessary arrangements for appropriate isolation or quarantine.
2. All persons, including visitors and other patients in the Emergency Department, clinical area or other areas of the hospital who had “close contact” with a suspect SARS case should be referred to the local health department to be monitored for development of fever or respiratory symptoms. Local health department staff should ensure that contacts

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record their temperature twice daily, watch for signs of respiratory illness, and report to local health department staff daily during the ten days after their last exposure to a suspect SARS case.

3. Local health department staff should instruct close contacts that develop fever or respiratory symptoms to:
  - a. notify their health care providers immediately.
  - b. notify the local health department immediately.
  - c. alert their provider before seeking medical evaluation to ensure infection control measures will be in place at the time of their arrival to the facility.
  - d. follow appropriate infection control measures in the home.
  - e. limit activities outside of the home (e.g. school, work, daycare, etc.).
4. The local health department will interview and counsel all “close contacts” (*including emergency department and clinic staff, other patients, and visitors*), as well as review the educational materials (see information sheet, page 21) and provide a 24-hour local health department telephone hotline number for all contacts to use if they have additional questions or concerns after leaving the hospital.
5. Local health departments should give persons on home isolation instructions for infection control in the home (see page 22).

### B. Role of Health Care Facility Staff

1. Known close contacts of suspect SARS cases should be screened for fever or respiratory symptoms before visiting health care facilities and should be excluded from visiting if they have either fever or respiratory symptoms.
2. Health care staff should assist the local health departments in determining those who may be close contacts of cases.
3. Health care facilities should maintain a logbook of all staff entering rooms of suspect SARS cases or who were otherwise involved in the patient’s care, regardless of whether PPE was worn.
4. Staff should be instructed to watch for development of fever or respiratory symptoms during the 10 days after the last exposure to the suspect patient.

## VI. Management of Exposed Health Care Workers

### A. Asymptomatic health care workers

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1. Health care workers who have **unprotected high-risk exposures** to SARS should be excluded from duty (e.g. administrative leave) for 10 days following the exposure. Unprotected high-risk exposure is defined as presence in the same room as a probable SARS patient during a high-risk aerosol-generating procedure or event and where recommended infection control precautions are either absent or breached.
2. Health-care workers who are excluded from duty because of their exposure need not limit their activities outside of the healthcare setting, but should undergo active surveillance for symptoms, including measurement of body temperature twice daily and monitoring for respiratory symptoms for 10 days following exposure.
3. Health-care workers who have other unprotected exposures to patients with SARS need not be excluded from duty because of their exposure and need not limit their activities outside of the healthcare setting, but should undergo active surveillance for symptoms, including measurement of body temperature twice daily and monitoring for respiratory symptoms for 10 days following exposure.
4. Health-care workers who have cared for or otherwise been exposed to SARS patients while adhering to recommended infection control precautions should be instructed to be vigilant for fever and respiratory symptoms, including measurement of body temperature at least twice daily for 10 days following the last exposure to a SARS patient. These health-care workers should be contacted by occupational health, infection control or their designee regularly over the 10-day period following exposure to inquire about fever or respiratory symptoms.

### B. Symptomatic health care workers

1. Any health-care worker who has cared for or been exposed to a SARS patient who develops fever OR respiratory symptoms within 10 days following exposure should not report for duty, but should stay home and report symptoms to the appropriate facility point of contact immediately. If the symptoms begin while at work, the health-care worker should be instructed to immediately apply a surgical mask and leave the patient care area. Symptomatic health-care workers should use infection control precautions to minimize the potential for transmission and should seek health-care evaluation. **In advance of clinical evaluation health-care providers should be informed that the individual might have been exposed to SARS so arrangements can be made, as necessary, to prevent transmission to others in the health-care setting.**
2. If symptoms improve or resolve within 72 hours after first symptom onset, the person may be allowed after consultation with infection control and

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local public health authorities to return to duty and infection control precautions can be discontinued.

3. For persons who meet or progress to meet the case definition for SARS (e.g., develop fever and respiratory symptoms), infection control precautions should be continued until 10 days after the resolution of fever, provided respiratory symptoms are absent or improving.
4. If the illness does not progress to meet the case definition, but the individual has persistent fever\* or unresolving respiratory symptoms, infection control precautions should be continued for an additional 72 hours, at the end of which time a clinical evaluation should be performed. If the illness progresses to meet the case definition, infection control precautions should be continued as described above. If case definition criteria are not met, infection control precautions can be discontinued after consultation with local public health authorities and the evaluating clinician
5. Persons who meet or progress to meet the case definition for suspect SARS (e.g., develop fever and respiratory symptoms) or whose illness does not meet the case definition, but who have persistent fever or unresolving respiratory symptoms over the 72 hours following onset of symptoms should be tested for SARS coronavirus infection.

\*Clinical judgment should be used when evaluating patients for whom a measured temperature of  $>100.4^{\circ}\text{F}$  ( $>38^{\circ}\text{C}$ ) has not been documented. Factors that might be considered include patient self-report of fever, use of antipyretics, presence of immunocompromising conditions or therapies, lack of access to health care, or inability to obtain a measured temperature

### **VII. Management of Suspect SARS Cases in Ambulatory Care Settings**

SARS is transmitted predominately by close contact, however it is still important to identify persons who present in outpatient settings with symptoms consistent with SARS.

#### **A. Triage**

1. Staff should ask screening questions regarding fever, respiratory symptoms, travel history, and close contact with other SARS suspect cases when patients call in for an appointments, at triage, or as soon as possible after patient arrives.
2. The most recent case definition for SARS should be used as the basis for questions about travel history.

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3. Staff that are first points of contact should be trained to do SARS screening and to take appropriate measures if a suspect SARS case is identified.

### B. Infection Control

1. Infection control measures should be implemented for patients who have either fever or respiratory symptoms, and have had close contact with a SARS suspect case or who have a travel history to areas listed in the case definition.
2. Place a surgical mask on persons suspect of having SARS until they can be placed in a private room or area. If they are unable to wear a mask, ask them to cover their mouths with disposable tissue when talking, sneezing, or coughing.
3. Practice standard precautions; in addition wear eye protection for all patient contact.
4. Patients should be placed in contact isolation. Wear gowns and gloves for all patient contact and contact with the patient environment.
5. If available, patient should be placed in an AII room. When such rooms are not available, place patient in private room and keep door closed. Portable HEPA filtration units are recommended for use if available.
6. All persons entering the patient's room should wear a fit-tested N-95 respirator. If not available, wear surgical masks when in the patient's room.
7. Patients should wear a surgical mask when they are outside of the isolation room.

### **SARS (Severe Acute Respiratory Syndrome)** **Case Definitions**

**December, 2003**

#### **Clinical Criteria**

##### *Early illness*

- Presence of two or more of the following features: fever (might be subjective), chills, rigors, myalgia, headache, diarrhea, sore throat, rhinorrhea

##### *Mild-to-moderate respiratory illness*

- Temperature of  $> 100.4^{\circ}\text{F}$  ( $>38^{\circ}\text{C}$ )<sup>1</sup>

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- One or more clinical findings of lower respiratory illness (e.g. cough, shortness of breath, difficulty breathing)

### *Severe respiratory illness*

- Meets clinical criteria of mild-to-moderate respiratory illness, and
- One or more of the following findings:
  - Radiographic evidence of pneumonia, *or*
  - Acute respiratory distress syndrome, *or*
  - Autopsy findings consistent with pneumonia or acute respiratory distress syndrome without an identifiable cause

### **Epidemiologic Criteria**

#### *Possible exposure to SARS-associated coronavirus (SARS-CoV)*

One or more of the following exposures in the 10 days before onset of symptoms:

- Travel to a foreign or domestic location with documented or suspect recent transmission of SARS-CoV2, *or*
- Close contact<sup>3</sup> with a person with mild-to-moderate or severe respiratory illness and with history of travel in the 10 days before onset of symptoms to a foreign or domestic location with documented or suspect recent transmission of SARS-CoV<sup>2</sup>

#### *Likely exposure to SARS-CoV*

One or more of the following exposures in the 10 days before onset of symptoms:

- Close contact<sup>3</sup> with a confirmed case of SARS-CoV disease, *or*
- Close contact<sup>3</sup> with a person with mild-moderate or severe respiratory illness for whom a chain of transmission can be linked to a confirmed case of SARS-CoV disease in the 10 days before onset of symptoms

### **Laboratory Criteria**

Tests to detect SARS-CoV are being refined, and their performance characteristics assessed; therefore, criteria for laboratory diagnosis of SARS-CoV are changing<sup>4</sup>. The following are the general criteria for laboratory confirmation of SARS-CoV:

- Detection of serum antibody to SARS-CoV by a test validated by CDC (e.g., enzyme Immunoassay [EIA]), *or*
- Isolation in cell culture of SARS-CoV from a clinical specimen, *or*
- Detection of SARS-CoV RNA by a reverse-transcription-polymerase chain reaction (RT-PCR) test validated by CDC and with subsequent confirmation in a reference laboratory (e.g., CDC)

Information regarding the current criteria for laboratory diagnosis of SARS-CoV is available at <http://www.cdc.gov/ncidod/sars/labdiagnosis.htm>

### **Exclusion Criteria**

**A person may be excluded as a SARS report under investigation (SARS RUI), including as a CDC-defined probable SARS-CoV case, if any of the following applies:**

- An alternative diagnosis can explain the illness fully<sup>5</sup>
- Antibody to SARS-CoV is undetectable in a serum specimen obtained >28 days after onset of illness<sup>6</sup>
- The case was reported on the basis of contact with a person who was excluded subsequently as a case of SARS-CoV disease; then the reported case also is excluded, provided other epidemiologic or laboratory criteria are not present

### ***Case Classification***

#### **SARS RUI**

*Reports in persons from areas where SARS is not known to be active:*

- SARS RUI-1: Patients with severe illness compatible with SARS in groups likely to be first affected by SARS-CoV if SARS-CoV is introduced from a person without clear epidemiologic links to known cases of SARS-CoV disease or places with known ongoing transmission of SARS-CoV

*Reports in persons from areas where SARS activity is occurring:*

- SARS RUI-2: Patients who meet the current clinical criteria for mild-to-moderate illness and the epidemiologic criteria for possible exposure (spring 2003 CDC definition for suspect cases<sup>8</sup>)
- SARS RUI-3: Patients who meet the current clinical criteria for severe illness and the epidemiologic criteria for possible exposure (spring 2003 CDC definition for probable cases<sup>8</sup>)
- SARS RUI-4: Patients who meet the clinical criteria for early or mild-moderate illness and the epidemiologic criteria for likely exposure to SARS-CoV

#### **SARS-CoV disease classification**

- Probable case of SARS-CoV disease: in a person who meets the clinical criteria for severe respiratory illness and the epidemiologic criteria for likely exposure to SARS-CoV
- Confirmed case of SARS-CoV disease: in a person who has a clinically compatible illness (i.e., early, mild-to-moderate, or severe) that is laboratory confirmed

<sup>1</sup>A measured documented temperature of >100.4° F (>38° C) is expected. However, clinical judgment may allow a small proportion of patients without a documented fever to meet this criterion. Factors that might be considered include patient's self-report of fever, use of antipyretics, presence of immunocompromising conditions or therapies, lack of access to health care, or inability to obtain a measured temperature. Initial case classification based on reported information might change, and reclassification might be required.



<sup>2</sup>Types of locations specified will vary (e.g., country, airport, city, building, floor of building). The last date a location may be a criterion for exposure for illness onset is 10 days (one incubation period) after removal of that location from CDC travel alert status. The patient's travel should have occurred on or before the last date the travel alert was in place. Transit through a foreign airport meets the epidemiologic criteria for possible exposure in a location for which a CDC travel advisory is in effect. Information regarding CDC travel alerts and advisories and assistance in determining appropriate dates are available at <http://www.cdc.gov/ncidod/sars/travel.htm>

<sup>3</sup>Close contact is defined as having cared for or lived with a person with SARS or having a high likelihood of direct contact with respiratory secretions and/or body fluids of a person with SARS (during encounters with the patient or through contact with materials contaminated by the patient) either during the period the person was clinically ill or within 10 days of resolution of symptoms. Examples of close contact include kissing or embracing, sharing eating or drinking utensils, close conversation (<3 feet), physical examination, and any other direct physical contact between persons. Close contact does not include activities such as walking by a person or sitting across a waiting room or office for a brief time.

<sup>4</sup>The identification of the etiologic agent of SARS (SARS-CoV) led to the rapid development of EIAs and immunofluorescence assays (IFAs) for serologic diagnosis and RT-PCR assays for detection of SARS-CoV RNA in clinical samples. These assays can be very sensitive and specific for detecting antibody and RNA, respectively, in the later stages of SARS-CoV disease. However, both are less sensitive for detecting infection early in illness. The majority of patients in the early stages of SARS-CoV disease has a low titer of virus in respiratory and other secretions and requires time to mount an antibody response. SARS-CoV antibody tests might be positive as early as 8–10 days after onset of illness and often by 14 days after onset of illness, but sometimes not until 28 days after onset of illness. Information regarding the current criteria for laboratory diagnosis of SARS-CoV is available at <http://www.cdc.gov/ncidod/sars/labdiagnosis.htm>

<sup>5</sup>Factors that may be considered in assigning alternate diagnoses include the strength of the epidemiologic exposure criteria for SARS-CoV disease, the specificity of the alternate diagnostic test, and the compatibility of the clinical presentation and course of illness for the alternative diagnosis.

<sup>6</sup>Current data indicate that >95% of patients with SARS-CoV disease mount an antibody response to SARS-CoV. However, health officials may choose not to exclude a case based on lack of a serologic response if reasonable concern exists that an antibody response could not be mounted.

<sup>7</sup>Consensus guidance between CDC and CSTE on which groups are most likely to be first affected by SARS-CoV if it re-emerges is in development. In principle, SARS-CoV disease should be considered at a minimum in the differential diagnosis for persons requiring hospitalization for radiographically confirmed pneumonia or acute respiratory distress syndrome without identifiable etiology and who have one of the following risk factors in the 10 days before the onset of illness:

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- Travel to mainland China, Hong Kong, or Taiwan, or close contact with an ill person with a history of recent travel to one of these areas, *or*
- Employment in an occupation associated with a risk for SARS-CoV exposure (e.g., healthcare worker with direct patient contact or worker in a laboratory that contains live SARS-CoV), *or*
- Part of a cluster of cases of atypical pneumonia without an alternative diagnosis

Guidelines for the identification, evaluation, and management of these persons are available at <http://www.cdc.gov/ncidod/sars/absenceofsars.htm>

<sup>8</sup>During the 2003 SARS epidemic, CDC case definitions were the following:

### *Suspect case*

- Meets the clinical criteria for mild-to-moderate respiratory illness and the epidemiologic criteria for possible exposure to SARS-CoV but does not meet any of the laboratory criteria and exclusion criteria, *or*
- Unexplained acute respiratory illness resulting in death in a person on whom an autopsy was not performed and who meets the epidemiologic criteria for possible exposure to SARS-CoV but does not meet any of the laboratory criteria and exclusion criteria

### *Probable case*

- Meets the clinical criteria for severe respiratory illness and the epidemiologic criteria for possible exposure to SARS-CoV but does not meet any of the laboratory criteria and exclusion criteria

For more information, visit [www.cdc.gov/ncidod/sars](http://www.cdc.gov/ncidod/sars) or call the CDC public response hotline at (888) 246-2675 (English), (888) 246-2857 (Español), or (866) 874-2646 (TTY)

## **Infection Control Precautions during Aerosol-Generating Procedures on Patients with SARS**

During the initial outbreak of SARS, it was determined that aerosol-generating procedures performed on SARS patients may increase the risk of SARS transmission.

Health care workers should be informed that aerosol-generating procedures (e.g. aerosolized medication treatment, sputum induction, bronchoscopy, airway suctioning, endotracheal intubation, or positive pressure ventilation such as BiPAP, CPAP, HFOC) can increase the risk of transmission of SARS. The following precautions should be taken whenever aerosol-generating procedures must be performed.

### **Limit opportunities for exposure.**

- Perform aerosol-generating procedures only when medically necessary.

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- Use clinically appropriate sedation during intubation and bronchoscopy to minimize resistance and coughing during procedure.
- Only health care workers who are essential to patient care should be in the room when procedures are done.

### **Perform procedures in appropriate settings.**

- If the patient is in an airborne isolation room, perform the procedure in that setting.
- If an airborne isolation room is not available, perform the procedure in a private room, away from other patients. If possible, increase air exchanges, create negative pressure relative to hallways, and avoid recirculation of room air. If recirculation is unavoidable, the air should be filtered through a HEPA filter as recommended for *Mycobacterium tuberculosis*.
- Keep door to rooms in which procedures are being done closed except when entering or exiting the rooms.
- Traffic in and out of rooms should be limited during procedures.

### **Use filters on ventilation exhaust valves.**

- Although the effectiveness of filters is unknown, it may be prudent to use bacterial/viral filters on exhalation valves of ventilators to prevent contaminated aerosols from entering the environment.

### **Wear personal protective equipment.**

- The optimal combination of personal protective equipment (PPE) to be worn during aerosol-generating procedures is still unknown.
- Current recommendations require PPE to cover the arms, torso, and fully protect the mouth, nose, and eyes.
- Consider additional PPE to cover all areas of skin.
- The following PPE is recommended for all those present during an aerosol-generating procedure:
  - Single isolation gown to protect body and exposed areas of arms. Use of a full-bodied isolation suit may be considered, as it provides greater protection for the neck area.
  - Single pair of disposable gloves that fit snugly over the wrists.
  - Eye protection consisting of goggles that fit snugly around the eyes.
  - Respiratory protection for aerosol-generating procedures must ensure that HCWs are protected from exposure to aerosolized infectious droplets through breaches in respirator seal integrity. Healthcare facilities should consider the following options:
    - Disposable particulate respirators (e.g. N-95, N-99, or N-100) are sufficient for routine respiratory protection for airborne precautions and are the minimum level of respiratory protection for HCWs who are performing aerosol-generating procedures. To ensure adequate protection, HCWs must be fit-tested to the

respirator model that they will wear (see TB Respiratory Protection Program In Health Care Facilities: Administrator's Guide).

- A fit-check should be performed each time the respirator is put on.
- At this time there is inadequate information to determine whether higher levels of respiratory protection (e.g. powered air purifying respirators,) will further reduce transmission. Factors that should be considered in choosing respirators in this setting include availability, impact on mobility and comfort.

**Adhere to safe work practices.**

- Aerosol-generating procedures have the potential to create high concentrations of the SARS virus in the air and on environmental surfaces. Avoid touching face or PPE on face with contaminated gloves. Avoid contaminating the surfaces around the patient and in the room.
- Use care when removing PPE to avoid contamination of skin, clothing, and mucous membranes (see guide for appropriate removal of PPE).
- Perform hand hygiene after removing PPE and before leaving patient room.

**Decontaminate PPE and environmental surfaces.**

- Decontaminate reusable PPE with an EPA registered hospital approved disinfectant.
- Wear clean gloves when wiping surfaces of equipment.
- Clean and disinfect horizontal surfaces in the room where aerosol-generating procedures have been done as soon as possible, and before other patients or health care workers enter the room.

**Procedure for Removing Personal Protective Equipment (PPE)**

During the SARS outbreak in Toronto, it was thought that contaminated PPE may have been a potential source of infection of health care workers, thus the manner in which it is removed may be important. The following method is one suggestion for removing PPE while minimizing risk of contamination of clothing, skin, and mucous membranes. It is based on the use of disposable PPE, and utilizes the principle of removing PPE from the facial area with clean hands.

1. Before leaving the isolation room or ante room, remove the disposable gown by grasping it at the shoulders, pulling down, and rolling inside out. Keep the contaminated outside of the gown away from the body.
2. Remove gloves with the clean side of the gown while rolling it down. Keep hands on the clean side of the gown.

3. Gown and gloves may be disposed of in regular trash unless grossly soiled with blood or other body fluids.
4. Wash hand with soap and water or sanitize with alcohol gel.
5. Remove PPE from face (face shield, goggles) while inside the isolation room or anteroom, except for the N-95 respirator.
6. Immediately after leaving the isolation room or ante room, remove N-95 respirator, touching only straps at back of head and dispose of in regular trash.
7. Wash hands with soap and water or sanitize with alcohol gel. Do not touch face until hands are decontaminated.

### **Information for SARS Patients and Their Close Contacts (name and contact info for LHD)**

#### **What is SARS?**

**Severe acute respiratory syndrome (SARS) is a respiratory illness caused by a new virus called the SARS-associated coronavirus (SARS-CoV). SARS was first reported in Asia in February 2003. The illness spread to many countries in North America, South America, Europe, and Asia over the next few months. It is possible that SARS could appear again in the next fall and winter season.**

#### **What are the symptoms of SARS?**

SARS usually begins with a high fever (temperature greater than 100.4° F). Other symptoms may include headache, body aches, and a general feeling of discomfort. Some people also have mild respiratory symptoms early in the disease. A few people also experience diarrhea. After about 2 to 7 days, a dry cough may develop, and most people will get pneumonia.

#### **How is SARS spread?**

The main way SARS is spread is by being in close contact with a person who has SARS. When an infected person coughs or sneezes, droplets may be forced out and travel a short distance (usually up to 3 feet). The droplets may then enter the nose, mouth, or eyes of a person who is in close contact with a SARS patient.

SARS can also be spread when a person touches a contaminated surface or object and then touches his or her nose, mouth, or eyes. It might also be possible for the SARS virus to be spread through the air for distances of several feet, or by other ways not yet known.

#### **Who is a “close contact” of SARS?**

**A close contact is someone who has cared for or lived with someone with SARS or someone who has had contact with respiratory secretions or body fluids of someone with SARS. Examples of close contact are kissing, hugging, sharing drinking cups, dishes, or silverware, talking to someone within 3 feet, or touching a SARS patient directly.**

### **What is the treatment for SARS?**

**SARS is caused by a virus, therefore antibiotics are not effective and are not used in treating the disease. Patients are usually treated for fever or respiratory symptoms, depending on the severity of their illness.**

### **If you think you or someone in your family might have SARS, you should:**

- Consult your doctor as soon as possible. Call ahead before you go to the clinic or urgent care, so they can be ready to help prevent your illness from spreading to others.
- Cover your mouth and nose with tissue when coughing or sneezing. You may be asked to wear a surgical mask when you get to the health care facility.

### **Instructions for SARS Patients on Home Care (name and contact info for LHD)**

### **If you have SARS and are being cared for at home:**

- Follow the instructions your doctor gave you.
- Stay at home. Do not go to work, school, daycare, or any other public areas.
- Wash your hands often, especially after blowing your nose. You may wash with soap and warm water or use an alcohol-based waterless hand gel.
- If possible, wear a surgical mask when you are around other people in the home. If you cannot wear a mask, others around you should wear a surgical mask when they are near you.
- Cover your mouth and nose with tissue when you sneeze or cough. Wash hands after throwing away the tissue.
- Don't share dishes, drinking cups, or silverware, towels or bedding with anyone else until they have been washed with soap and hot water.
- Clean countertops, tabletops, doorknobs, bathroom fixtures, and any other surfaces that have been contaminated by body fluids (sweat, saliva, mucous, vomit, urine). Use a household disinfectant such as Lysol™ or bleach according to the directions on the label. Disposable gloves should be worn while cleaning. Throw the gloves away when finished cleaning—do not reuse.
- Follow these instructions for 10 days after your fever is gone, and your respiratory symptoms are gone or getting better.

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- When the 10 days have past, call your local health department to make sure you can return to work or school.

### **If you are taking care of someone at home who has SARS:**

- Make sure the person with SARS has seen a health-care provider and is following instructions for medication and care.
- Make sure all members of your household are washing their hands frequently with soap and warm water or using alcohol-based hand wash.
- Wear disposable gloves if you have direct contact with body fluids of a SARS patient. However, the wearing of gloves is not a substitute for good hand hygiene. After contact with body fluids of a SARS patient, remove the gloves, throw them out, and wash your hands. Do not wash or reuse the gloves.
- Encourage the person with SARS to cover his or her mouth and nose with a tissue when coughing or sneezing.
- If possible, the person with SARS should wear a surgical mask during close contact with other people in the home. If the person with SARS cannot wear a surgical mask, other members of the household should wear one when in the room with that person.
- Do not use silverware, towels, bedding, clothing, or other items that have been used by the person with SARS until these items have been washed with soap and hot water.
- Clean surfaces (counter or tabletops, doorknobs, bathroom fixtures, etc.) that have been contaminated by body fluids (sweat, saliva, mucous, or even vomit or urine). Use a household disinfectant such as Lysol™ or bleach according to the **directions** on the label. Wear disposable gloves during all cleaning activities. Throw these out when done. Do not reuse them. Follow these instructions for 10 days after the sick person's fever is gone or getting better. Call your doctor if you develop fever or respiratory symptoms.

## Attachment 6

## Infection Control Practices in Health Care Settings—Select Agents

<b>IMPORTANT PHONE NUMBERS:</b>  WI DPH:  CDC Emergency Response Office:  Poison Control: -	<b>BACTERIAL AGENTS</b>								<b>VIRUSES</b>					<b>BIOLOGICAL TOXINS</b>			
	Anthrax	Brucellosis	Cholera	Bubonic Plague	Pneumonic Plague	Tuberculosis	Tularemia	Q Fever	SARS	Small Pox	Venez Equine Enceph	Viral Encephalitis	Viral Hemor Fever	Botulism	Ricin	T-2 Mycotoxins	Staph, Enterotoxin B
<b>Isolation Precautions</b>																	
Standard Precautions for all aspects of patient care	X	X	X	X	X	X	X	X	X	X	X	X	X	X	X	X	X
Contact Precautions			X						X	X		~	X				
Airborne Precautions						X			X	X			X				
Use of <b>N95</b> mask by <b>all</b> individuals entering the room						X			X	X			X				
Droplet Precautions / surgical mask					X						X						
Wash hands with antimicrobial soap/hand sanitizer	X	X	X	X	X	X	X	X	X	X	X	X	X	X	X	X	X
Eye protection during all pt contact (goggles/face shield)									X	X			X				
<b>Patient Placement</b>																	
No restrictions	X	X		X				X				~		X	X	X	X
Cohort like patients If private room unavailable			X		X				X	X	X	~	X				
Private Room (cohort if private room unavailable)			X		X	X			X	X	X	~	X				
Negative Pressure Room Required						X			X	X			X				
Door closed at all times						X			X	X			X				
<b>Patient Transport</b>																	
No restrictions	X	X		X				X				~		X	X	X	X
Limit movement to essential medical purposes only			X		X	X			X	X	X	~	X				



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<b>IMPORTANT PHONE NUMBERS:</b>  <b>WI DPH:</b>  <b>CDC Emergency Response Office:</b>  <b>Poison Control:</b> -	<b>BACTERIAL AGENTS</b>	Anthrax	Brucellosis	Cholera	Bubonic Plague	Pneumonic Plague	Tuberculosis	Tularemia	Q Fever	<b>VIRUSES</b>	SARS	Small Pox	Venez Equine Enceph	Viral Encephalitis	Viral Hemor Fever	<b>BIOLOGICAL TOXINS</b>	Botulism	Ricin	T-2 Mycotoxins	Staph, Enterotoxin B
						X	X				X	X	X		X					
Place mask on patient to minimize dispersal of droplets																				
<b>Cleaning, Disinfection of Equipment</b>																				
Routine terminal cleaning of room with hospital approved disinfectant upon discharge			X	X	X	X	X	X	X		X	X	X	X			X	X	X	X
Disinfect surfaces with bleach/water solution 1:9 (10% solution)		X													X					
Dedicated equipment that is disinfected prior to leaving room				X				⊖			X	X		~	X					
Linen management as per policy		X	X	X	X	X	X	X	X		X	X	X	X	X		X	X	X	X
Waste per Infectious Waste policy		X	X	X	X	X	X	X	X		X	X	X	X	X		X	X	X	X
<b>Post-Mortem Care</b>																				
Follow principles of Standard Precautions		X	X	X	X	X	X	X	X		X	X	X	X	X		X	X	X	X
Droplet Precautions						X														
Airborne Precautions						@	X				X	X			X					
Use of <b>N95</b> mask by <b>all</b> individuals entering the room							X				X	X			X					
Negative Pressure							X				X	X			X					
Contact Precautions											X	X			X					
Routine terminal cleaning of room with hospital approved disinfectant upon autopsy			X	X	X	X	X	X	X		X	X	X	X			X	X	X	X
Disinfect surfaces with bleach/water solution 1:9 (10% solution)		X													X					

**STANDARD PRECAUTIONS:** Prevents direct contact with all body fluids including blood, secretions, excretions, non intact skin (including rashes) and mucous membranes. Standard Precautions practiced by healthcare providers include: Handwashing, gloves when contact with the above, mask/eye protection/face shield while performing procedures that cause splash, spray, and gowns to protect skin and clothing during procedures.

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<b>IMPORTANT PHONE NUMBERS:</b>  WI DPH:  CDC Emergency Response Office:  Poison Control: -	<b>BACTERIAL AGENTS</b>
	<b>Anthrax</b>
	<b>Brucellosis</b>
	<b>Cholera</b>
	<b>Bubonic Plague</b>
	<b>Pneumonic Plague</b>
	<b>Tuberculosis</b>
	<b>Tularemia</b>
	<b>Q Fever</b>
	<b>VIRUSES</b>
	<b>SARS</b>
	<b>Small Pox</b>
	<b>Venez Equine Enceph</b>
	<b>Viral Encephalitis</b>
	<b>Viral Hemor Fever</b>
<b>BIOLOGICAL TOXINS</b>	<b>Botulism</b>
	<b>Ricin</b>
	<b>T-2 Mycotoxins</b>
	<b>Staph, Enterotoxin B</b>

⊕ Contact precautions when open lesions are present.

~depends on etiologic agent

@ airborne precautions for aerosol generating procedures

## Infection Control Practices For Local Health Department Staff Visiting Cases on Home Isolation

### Selected Biological Agents

<u>Disease</u>	<b>Precautions</b>	<b>Isolation Period</b>	<b>Quarantine of Contacts</b>
<b>Bacterial Agents</b>			
Anthrax	<b>Standard</b>	N/A	No
Brucellosis	Standard	N/A	No
Cholera	Standard Contact precautions for children less than 6 years old	Duration of illness	No
Bubonic plague	Standard	N/A	No
<b><u>Pneumonic plague</u></b>	<b><u>Standard</u></b> Droplet	From symptom onset until 72 hours after effective antibiotic therapy has been initiated	No
Tularemia	Standard	N/A	No
Q fever	Standard	N/A	No
<b>Viruses</b>			
SARS	Standard Airborne Contact Eye protection	Onset of fever or cough until 10 days after fever resolves and respiratory symptoms are improving	Health care workers exposed to probable case during aerosol generating procedures (see SARS guidelines Appendix II)
Smallpox	Only vaccinated staff are to be in contact with suspect cases Standard Airborne Contact Eye protection	Appearance of early lesions until all lesions have fallen off	Close contacts may be quarantined (see Appendix I in Quarantine Section).
Viral hemorrhagic fever	Standard Airborne Contact Eye protection	Duration of illness	No

### Standard Precautions

Standard precautions are used to prevent transmission of diseases that can be contracted by contact with blood, body fluids, non-intact skin (including rashes), and mucous membranes. These measures are to be used on **all** individuals, whether or not they are considered infectious or symptomatic.

- Hand washing
  - Wash hands before and after examining an individual.
  - Wash hands immediately after touching blood, body fluids, non-intact skin, mucous membranes, or contaminated items, even when gloves were worn during contact.
  - Alcohol gel may be used as an alternative to washing with soap and water.
- Personal Protective Equipment (PPE)
  - Wear gloves when touching blood, body fluids, non-intact skin, mucous membranes, and contaminated items.
  - Wear a surgical mask and goggles or face shield if there is a reasonable chance that a splash or spray of blood or body fluids may occur to the eyes, mouth, or nose.
  - Wear a gown if skin or clothing is likely to be exposed to blood or body fluids.
  - Remove PPE immediately after use and wash hands.
  - If PPE is saturated with blood or other body fluids such that fluid may be poured, squeezed, or dripped from the item, discard into a plastic leak-proof bag, seal, and place in a second leak-proof bag. PPE that is not saturated may be placed directly in the trash. Waste generated from the home may be placed out for regular pick-up by waste management services.
- Sharps
  - Any used needles, lancets, or other contaminated sharps should be placed in a hard plastic or metal container with a screw-on or tightly secured lid. The containers may be taken to a collection facility such as an area pharmacy, hospital, or clinic that provides this service.

### Contact Precautions

**Use the following measure in addition to standard precautions when in contact with individuals known or suspected of having diseases spread by direct or indirect contact.**

- Wear gloves and gown when in contact with the individual, surfaces, or objects within his/her environment.
- All re-usable items taken into the home should be cleaned and disinfected before taken back out of the home.

### Droplet Precautions

Use the following measure in addition to standard precautions when in contact with individuals known or suspected of having diseases spread by droplets.

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- Wear a surgical mask when within 3 feet of the individual (6 feet if person is suspected to have smallpox).

### Airborne Precautions

Use the following measures in addition to standard precautions when in contact with individuals known or suspected to have diseases spread by fine particles dispersed by air currents.

- Put on a fit-tested N-95 respirator just before entry into the home and wear at all times while in the home of the individual. Remove and discard respirator just after exiting the home. The respirator may be discarded in to the regular trash unless contact precautions must also be followed. In this case, place the respirator in a plastic zip-lock bag, seal and then discard into a second plastic bag.
- If available, portable High Efficiency Particulate Air filtration units may be operated in the home in the area where the individual is located to filter out infectious particles.

### Eye Protection

If eye protection is indicated, wear goggles or a face shield during all contact with the individual, not just when splashes or sprays are anticipated, as with standard precautions.

## Initial Management of Clients with Potential Communicable Diseases Local Health Departments and Tribal Health Centers

Persons seeking assistance at local health departments or tribal health centers may occasionally present with potentially communicable diseases. Use of appropriate infection control measures will help reduce the risk of spreading those diseases to staff and other visitors in the facility. The following guidelines are for use when providing consultation or triage. If clients need medical examinations, additional infection control measures may be necessary (see appendix III, “).

1. Train staff and others who have initial contact with clients to recognize common symptoms of communicable diseases and to take appropriate steps to protect themselves and others from possible spread of the disease (see table below).
2. Make items such as tissues, waste containers, and alcohol hand sanitizers available at entrances or in waiting areas for client use.
3. Maintain a supply of surgical masks and disposable or cloth coverings that are readily available when clients enter the facility.

	Signs/Symptoms	Infection Control	Disposition
<b>Respiratory Symptoms</b>	Acutely ill with fever or cough, no relevant travel history.	Ask client to practice respiratory hygiene: Cover nose and mouth with tissue while coughing or sneezing, discard tissue, wash hands (or sanitize with alcohol hand gel). Remove client to area away from others if possible.	Send to medical facility or home, depending on severity of symptoms
	Acutely ill with fever or cough and history of recent travel or exposure to persons traveling in countries where SARS is or has occurred or where Avian influenza is occurring.	Ask client to wear surgical mask if tolerated or practice respiratory hygiene. Remove client to area away from others if possible.	<ul style="list-style-type: none"> <li>• If sent home: monitor client for progression of illness and/or place on home isolation, depending on current CDC guidelines.</li> <li>• If sent to medical facility: notify facility in advance and ask client to wear surgical mask during transport and upon entry into facility.</li> </ul>

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	<b>Signs/Symptoms</b>	<b>Infection Control</b>	<b>Disposition</b>
	Cough for $\geq 3$ weeks, sputum blood tinged, night sweats, weight loss, history of TB or of TB exposure. May or may not have a fever.	Ask client to wear surgical mask if tolerated or practice respiratory hygiene. Remove client to area away from others if possible.	<ul style="list-style-type: none"> <li>• Send to medical facility for evaluation.</li> <li>• Notify facility in advance.</li> <li>• Ask client to wear surgical mask during transport and when entering facility.</li> </ul>
<b>Rash</b>	Rash without fever. Rash with drainage.	Cover all lesions and contain drainage.	Send home or to medical facility depending on medical condition.
	Rash with fever. Rash with fluid-filled pustules. Rash on more than one area of the body. May or may not have cough.	If coughing, ask client to wear surgical mask if tolerated or practice respiratory hygiene. Cover all lesions and contain any drainage.	<ul style="list-style-type: none"> <li>• Low risk of smallpox: send client home or to medical facility if condition warrants.</li> <li>• Moderate to high risk of smallpox: send to medical facility, notify facility in advance, make sure client wears surgical mask and all lesions are covered during transport and upon entry into facility.</li> </ul>
<b>Neurological Symptoms</b>	Headache with fever, eyes sensitive to light, neck stiffness	Ask client to wear surgical mask.	<ul style="list-style-type: none"> <li>• Send to medical facility for evaluation.</li> <li>• Notify facility in advance.</li> </ul>
	Confusion, Uncooperative, hitting, spitting, with or without fever.	<u>Client should be masked.</u>	<ul style="list-style-type: none"> <li>• Send to medical facility</li> <li>• Notify facility in advance</li> <li>• Client should wear mask during transport and upon entry into facility</li> </ul>

## Sample Voluntary Client Isolation Contract

To: (Individual's name, address & date of birth)

Because you [*have/are thought to have*][*suspected/confirmed*](circle correct terms)  
 \_\_\_\_\_(*name of infectious disease*) there is a risk you could transmit this disease to  
 others. Therefore to protect people around you, please remain at \_\_\_\_\_  
 \_\_\_\_\_ until your illness is cleared or is no longer thought to be  
 infectious. When you are confirmed as no longer infectious, you will be able to move freely  
 about the community. We will monitor your clinical condition regularly and we will let you  
 know how you are progressing.

The clinical findings that point to \_\_\_\_\_(name of infectious disease) are:

*Chapter 252 of the Wisconsin state statutes and chapter 145 of the Administrative Rules give local and state health departments the authority to control infectious diseases by use of isolation and quarantine. Violation of isolation or quarantine measures could result in legal action through the courts.*

I, \_\_\_\_\_, agree voluntarily to:

- ☐ Remain in \_\_\_\_\_ until the Health Department releases me.
- ☐ Have no contact with people outside of \_\_\_\_\_.
- ☐ Have no person into \_\_\_\_\_ except the designated public health staff or any other person given permission by the Health Department.
- ☐ Remain in isolation precautions until such time as I have medical verification from the health department that I am no longer infectious.
- ☐ Contact the health department for assistance if I am having any difficulty maintaining this agreement, have any changes in symptoms or if I become aware of anyone else with whom I was previously in contact who should undergo an evaluation.
- ☐ Arrangements for medical appointments will be made by \_\_\_\_\_.
- ☐ I understand that the health department will visit me regularly to evaluate how I am doing and to ensure that I am remaining in isolation.

**Client:** \_\_\_\_\_ **Date** \_\_\_\_/\_\_\_\_/\_\_\_\_  
                                 Client Signature                         Month/Day/Year

---

**Witness** \_\_\_\_\_ **Date** \_\_\_\_/\_\_\_\_/\_\_\_\_  
                                 Optional Witness Signature                         Month/Day/Year

---

**Health Department Staff:** \_\_\_\_\_ **Date** \_\_\_\_/\_\_\_\_/\_\_\_\_  
   Signature & Title                         Month/Day/Year

One copy to client. One copy to health department.



## Sample Isolation Orders

To: (Individual's Name, Address and Date of Birth)

I, \_\_\_\_\_, Health Officer for \_\_\_\_\_, have been  
(Local Health Officer) (City/County)  
informed that you have [suspected or confirmed] (select one) \_\_\_\_\_, and there is  
a risk that you could transmit this disease to others.

This determination of [suspected or confirmed] (select one) \_\_\_\_\_ is based on the  
following findings:

*Chapter 252 of the Wisconsin state statutes and chapter 145 of the Administrative Rules give local and state health departments the authority to control infectious diseases by use of isolation and quarantine. Violation of isolation or quarantine measures could result in legal action through the courts.*

In light of my legal obligation to protect the health of the public, you are ordered to:

1. Remain in \_\_\_\_\_.
2. Have no contact with people outside of \_\_\_\_\_.
3. Have no other person enter \_\_\_\_\_ except my designated representatives or any other persons having special written consent from my office.
4. Remain in \_\_\_\_\_ until I notify you that I have medical verification that you are no longer infectious and I release you from isolation.

Arrangements for medical appointments will be made by \_\_\_\_\_.  
You will be visited by a health department representative to check on how you are getting along as required by Wisconsin Administrative Codes.

This order is effective as of this date, \_\_\_\_\_, and is to stay in effect until you are officially notified of your release from isolation precautions by my agent or me. A violation of this order will result in a request to the court for legal action to enforce your isolation to protect others from being infected.

\_\_\_\_\_  
Health Officer Signature Date \_\_\_\_/\_\_\_\_/\_\_\_\_  
Month/Day/Year

Signature acknowledges receipt of the original order: \_\_\_\_\_ Date \_\_\_\_/\_\_\_\_/\_\_\_\_  
Client's Signature Month/Day/Year

Witness to service of isolation order: \_\_\_\_\_ Date \_\_\_\_/\_\_\_\_/\_\_\_\_  
Witness Signature Month/Day/Year

Served by: \_\_\_\_\_ Date \_\_\_\_/\_\_\_\_/\_\_\_\_  
Signature Month/Day/Year

One copy to client. One copy to health department.

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Attachment 11

**Sample of Release from Isolation Form**

To: (Individual's Name, Address and Date of Birth)

I, \_\_\_\_\_, Health Officer for \_\_\_\_\_, have  
Health Officer Name City/County  
medical verification that you are no longer infectious and your condition is no longer  
considered a public health risk.

I am therefore releasing you from the isolation order issued on \_\_\_\_\_. You are free  
to move about the community, and are now able to follow up with your chosen health care  
provider if you have any further health care needs.

Please call the \_\_\_\_\_ Health Department at \_\_\_\_\_ with any  
public health questions you may have.

\_\_\_\_\_ Date \_\_\_\_/\_\_\_\_/\_\_\_\_  
Health Officer Signature Month/Day/Year

I acknowledge receipt of original order of release \_\_\_\_\_ Date \_\_\_\_/\_\_\_\_/\_\_\_\_  
Client's Signature Month/Day/Year

[Option of witness for release per local health department decision; eliminate the signature area below if not to  
be used:]

I witnessed issuance of release \_\_\_\_\_ Date \_\_\_\_/\_\_\_\_/\_\_\_\_  
Witness Signature Month/Day/Year

Served by \_\_\_\_\_ Date \_\_\_\_/\_\_\_\_/\_\_\_\_  
Signature & Title Month/Day/Year

One copy to client. One copy to health department.



**These premises are restricted to access. For your safety, do not enter unless you have permission from the Health Department.**

**Telephone Number** \_\_\_\_\_

\_\_\_\_\_  
Health Officer

\_\_\_\_\_  
Health Department

\_\_\_\_\_  
Date

## Attachment 13

**Use of Expanded Precautions, Including Emerging Diseases & Bioterrorism Agents**

The cause of an infectious illness may not be immediately identified in some cases, yet expanded precautions may be necessary to prevent further spread of a communicable disease. The following table lists conditions or symptoms that require empiric use of expanded precautions until etiologic agents are confirmed or ruled out.

**Clinical Syndromes Requiring Empiric Use of Expanded Precautions**

<b>Clinical Syndrome/Condition</b>	<b>Potential Infectious Agents</b>	<b>Expanded Precautions</b>
<b>Diarrhea</b>  Acute diarrhea with a likely infectious cause in an incontinent or diapered patient	Enteric pathogens and food/water safety threats such as <i>Salmonella</i> species, <i>E. coli</i> 0157:H7, <i>Shigella</i> , hepatitis A, rotavirus, <i>Vibrio cholerae</i> , <i>Cryptosporidium</i> , norovirus	Contact
Diarrhea in an adult with a history of recent antibiotic use	<i>Clostridium difficile</i>	
<b>Hemorrhage/fever</b>  Marked fever, fatigue, dizziness, bleeding under skin, internal organs, or body orifices.	Viral hemorrhagic fevers	Airborne Contact*
<b>Meningitis</b> Headache, vomiting, stiff neck	<i>Neisseria meningitidis</i>	Droplet
<b>Rash illnesses</b> Petechial/ecchymotic with fever	<i>Neisseria meningitidis</i>	Droplet
Vesicular or vesicular/pustular	<u><i>Varicella, smallpox*, monkeypox viruses</i></u>	Airborne Contact
<b>Respiratory illnesses</b> Cough/night sweats/fever, abnormal chest x-ray, esp. cavitation, infiltrate or fibrotic changes, or high-risk patient (foreign born, homeless, drug user, HIV+ or unknown status, previous TB or recently exposed to TB, congregate living, etc.)	<u><i>Mycobacterium tuberculosis</i></u>	Airborne
<u><b>Paroxysmal or severe persistent cough during periods of pertussis activity</b></u>	<u><b>Bordetella pertussis</b></u>	Droplet
Fever, headache, weakness, rapidly developing pneumonia	<i>Yersinia pestis</i> (pneumonic plague)	

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Clinical Syndrome/Condition	Potential Infectious Agents	Expanded Precautions
Atypical pneumonia of unknown etiology in healthcare workers, travelers to former SARS endemic areas, close contacts of persons with atypical pneumonia when SARS cases are NOT occurring in world.	SARS coronavirus	
Fever and mild to severe respiratory symptoms in persons who traveled to SARS endemic areas within 10 days of symptom onset or are close contacts of suspect SARS cases.		Airborne Contact*
Respiratory infections, particularly bronchiolitis and croup, in infants and young children	Respiratory syncytial or parainfluenza virus	Contact
<b>Risk of Drug Resistant Microorganisms</b> History of infection or colonization with drug resistant organisms, or Skin, wound, or urinary tract infection in a patient with a recent hospital or nursing home stay in a facility where multidrug-resistant organisms are prevalent	MRSA, VRE or other drug resistant bacteria	Contact
<b>Skin or wound infection</b> abscess or draining wound that cannot be covered	<i>Staphylococcus aureus</i> , group A streptococcus	Contact

\*Also requires eye protection for all patient contact.

**Personal Protective Equipment**

The following lists constitute the minimum standards for each level of PPE. More information about PPE requirements and appropriate levels of PPE for chemical exposures may be obtained from the Occupational Safety and Health Administration (OSHA) at [http://www.osha.gov/dts/osta/otm/otm\\_viii/otm\\_viii\\_1.html](http://www.osha.gov/dts/osta/otm/otm_viii/otm_viii_1.html). The National Institute of Occupational Safety and Health (NIOSH) has information on NIOSH-approved respirators in terrorism events at <http://www.cdc.gov/niosh/nppt/scbasite.html>.

- a. Level A (highest level of protection): a positive pressure self-contained breathing apparatus (SCBA) and a fully encapsulating, chemical protective suit.
- b. Level B (maximum respiratory protection but skin/eye hazards do not require Level A): an SCBA and a hooded chemical-resistant suit, butyl outer and SilverShield® inner gloves, and chemical resistant boots.
- c. Level C (less skin and respiratory protection than other levels): a full-face air purifying, canister-equipped respirator, hooded chemical-resistant suit, butyl outer and SilverShield® inner gloves, and chemical resistant boots.
- d. Level D (no respiratory protection and low skin protection): coveralls or nuisance contamination resistance clothing, SilverShield® or nitrile gloves, safety glasses or chemical splash goggles, chemical resistant boots or shoes, if indicated.

**Recommended Personal Protective Equipment for Local Public Health Depts.****1. N-95 disposable filtering face piece respirator**

This is already required for TB and is useful for other communicable diseases as well as other dust, fumes and mists. Depending on the type and extent of chemical contamination at the site it may be necessary to use special, chemical specific cartridges and go to a respirator with a higher protection factor.

**2. Disposable nitrile or vinyl examination gloves (preferably not latex)**

Use of gloves is a requirement of the OSHA Bloodborne Pathogen Standard for any situation where you might be exposed to blood or other potentially infectious material (OPIM). Nitrile gloves are also an effective barrier against most chemicals (at low levels). Typically, these gloves will be used while collecting environmental samples. Normally, these areas should not have high levels of contamination.

**3. Surgical masks with plastic eye shield** to protect mucus membranes from exposure to blood or OPIM.

Typically, surgical masks do not provide an effective barrier against chemicals and airborne environmental contaminants such as asbestos. Other appropriate respiratory protection should be secured. Eye protection, suitable to protect against physical hazards and air-borne chemicals and/or splashes, should be used. It is a requirement of the Bloodborne Standard that if you in a situation where you might have exposure to mucus membranes (nose & mouth) you must also have eye protection and vice versa. There are disposable surgical masks with a band of plastic attached to give eye protection as well.

**4. Surgical masks** if you run a clinic to give to patients with persistent coughs until various diseases are ruled out. This is a CDC recommendation for TB and SARS and other respiratory pathogens. Again, surgical masks are not adequate protection against chemicals and other environmental contaminants such as

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asbestos. While triaging patients it may be necessary for state, local health and emergency response/hospital personnel to don more protective respirators with the appropriate chemical cartridges.

5. **Rubber utility gloves** where you might have contamination and need to clean. Again, the choice of glove depends on the hazards and tasks. Surgical or exam gloves are not appropriate for cleaning floors and other surfaces. It is better to use a heavier glove, which is reusable and cleanable and more resistant to chemicals. If you are involved in aggressive activities such as cleaning ensure that the gloves are rated for handling chemical contamination.
6. **Regular utility (cloth) gloves** for brush and other clean up when involved in tornado, flood etc. providing protection against debris and brush.
7. **Reflective vests** so that you will be visible both day & night while working in the field as part of response.
8. **Rubber boots**, preferably steel toe and knee high for protection in the field from contaminants and debris during response and clean-up. On a case specific basis it may be appropriate to wear steel-toed insulated leather boots.
9. **Safety glasses** for eye protection when in the field to protect eyes from debris and dusts and other contaminants.
10. **Earplugs** for hearing protection. They need to be worn when sound levels exceed 85 dBA. For practical purposes this means working near generators, power equipment large engines and other sources.
11. **Tyvek coveralls (jump suits) with Duct tape** - Used for general cover-up on site (could also use cloth jump suits) from dirt and contaminants encountered during clean-up. Use extra large Tyvek suits and a roll of duct tape to alter (provide a belt etc) or have multiple sizes in stock.
12. **Knee pads** to protect from debris in the field and to provide ergonomic protection.
13. **Disposable impervious gowns** – used to protect clothing and skin from blood and other potentially infectious material under the bloodborne pathogens standard, and for encountering people with diseases spread by contact. This type of protection is not adequate for addressing chemical contamination.

Based on OSHA Requirements, each LPHD should have a written plan to show that employees have been medically evaluated for wearing a respirator and have been appropriately fit-tested. Please also refer to the employee protection requirements administered by the State Department of Commerce.

**Field Triage Record:** Fax at least daily to \_\_\_\_\_ (County Health Department) Date: \_\_\_\_\_ Page \_\_ of \_\_\_\_

[illegible]



**SPECIAL POPULATIONS CHECKLIST**

<b>1.0</b>	<b>COMMUNICATION AND INTERACTION – MASS</b>	<b>HOSPITAL</b>	<b>CLINIC</b>
1.1	Have signage – international symbols, Braille, English plus other two most common languages – at a 3 <sup>rd</sup> -4 <sup>th</sup> grade reading level		
1.2	Activate audio and visual alarms if the event is in a public building		
1.3	Activate procedures for utilization of translators and interpreters		
1.4	Activate procedures to allow attendants to stay with their clients		
1.5	Request visual media to use closed captioning and digital presentation for announcements		
1.6	Provide verbal communication slowly, repeatedly and at a limited language proficiency level in English and the two other most common languages		
1.7	Coordination with local 211 system to provide multi-lingual information for compliance with public health orders		
1.8	PIO's utilize non-English speaking media in addition to English speaking media		
1.9	PIO's maintain responsibility for integrity of communications through translations		
1.10	PIO's to activate procedures to utilize community special populations representatives at press conferences		
1.11	Review all written and spoken information for sensitivity to cultural, racial, religious and ethnic differences so as to not undermine compliance		
1.12	Locate supplies of batteries for hearing aids, TTY, etc.		
1.13	Locate supply of paper and pens for manual translation and interpretation		
2.0	<b>COMMUNICATION AND INTERACTION – INDIVIDUAL</b>		
2.1	Have signage – international symbols, Braille, English plus other two most common languages – at a 3 <sup>rd</sup> -4 <sup>th</sup> grade reading level		
2.2	Activate procedures for utilization of translators and interpreters		
2.3	Activate procedures to allow attendants to stay with their clients		
2.4	Provide verbal communication slowly, repeatedly and at a limited language proficiency level in English and the two		

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	other most common languages		
2.5	Activate appropriate special populations agency for assistance		
2.6	Review all written and spoken information for sensitivity to cultural, racial, religious and ethnic differences so as to not undermine compliance		
2.7	Locate supplies of batteries for hearing aids, TTY, etc.		
2.8	Locate supply of paper and pens for manual translation and interpretation		
3.0	<b>TRANSPORTATION – MASS</b>		
3.1	Determine if decontamination of any of the persons is necessary		
3.2	Access list of transport agencies and companies – public, private and handicapped accessible transportation providers		
3.3	Contact appropriate transport agencies and companies for transportation of persons affected		
3.4	Make certain that the drivers are trained in tie-downs and use of lifts		
3.5	Contact 211 to activate their system		
3.6	Coordinate transport information with 211		
3.7	Provide all transport information in – international symbols, Braille, English plus other two most common languages – at a 3 <sup>rd</sup> -4 <sup>th</sup> grade reading level		
3.8	Activate procedures to allow attendants to travel with the persons being transported		
3.9	Activate procedures that will allow transportation of families or households as units		
4.0	<b>TRANSPORTATION – INDIVIDUAL</b>		
4.1	Determine if decontamination of any of the persons is necessary		
4.2	Access list of transport agencies and companies – public, private and handicapped accessible transportation providers		
4.3	Contact appropriate transport agencies and companies for transportation of persons affected		
4.4	Make certain that the drivers are trained in tie-downs and use of lifts		
4.5	Provide all transport information in – international symbols, Braille, English plus other two most common languages – at a 3 <sup>rd</sup> -4 <sup>th</sup> grade reading level		

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4.6	Activate procedures to allow attendant to travel with the person being transported		
4.7	Activate procedures that will allow transportation of family member or household member with the person being transported		
5.0	<b>ACCOMMODATIONS DURING INTERVENTION – MASS</b>		
5.1	Have signage – international symbols, Braille, English plus other two most common languages – at a 3 <sup>rd</sup> -4 <sup>th</sup> grade reading level		
5.2	Activate procedures for utilization of translators and interpreters		
5.3	Activate procedures to allow attendants to stay with their clients		
5.4	Use extremely accessible facilities		
5.5	Access and staffing for a safe, secure area for infants and children		
6.0	<b>ACCOMMODATIONS DURING INTERVENTION – INDIVIDUAL</b>		
6.1	Have signage – international symbols, Braille, English plus other two most common languages – at a 3 <sup>rd</sup> -4 <sup>th</sup> grade reading level		
6.2	Activate procedures for utilization of translators and interpreters		
6.3	Activate procedures to allow attendants to stay with their clients		
6.4	Use extremely accessible facilities		
6.5	Access and staffing for a safe, secure area for infants and children		

## PART D

### LEGAL REFERENCES

**48.13 – Abandoned Children** Jurisdiction over children alleged to be in need of protection or services: The court has exclusive original jurisdiction over a child alleged to be in need of protection or serves which can be ordered by the court, and: 1) who is without a parent or guardian: 2) who is abandoned

#### 2. 55, 51, 880 Vulnerable Adults

##### **252.06 Isolation and Quarantine**

**252.06(1)** The department or the local health officer acting on behalf of the department may require isolation of a patient or of an individual under [s. 252.041 \(1\) \(b\)](#), quarantine of contacts, concurrent and terminal disinfection, or modified forms of these procedures as may be necessary and as are determined by the department by rule.

**252.06(3)** If a local health officer suspects or is informed of the existence of any communicable disease, the officer shall at once investigate and make or cause such examinations to be made as are necessary. The diagnostic report of a physician, the notification or confirmatory report of a parent or caretaker of the patient, or a reasonable belief in the existence of a communicable disease shall require the local health officer immediately to quarantine, isolate, require restrictions or take other communicable disease control measures in the manner, upon the persons and for the time specified in rules promulgated by the department. If the local health officer is not a physician, he or she shall consult a physician as speedily as possible where there is reasonable doubt or disagreement in diagnosis and where advice is needed. The local health officer shall investigate evasion of the laws and rules concerning communicable disease and shall act to protect the public.

**252.06(4)(a)** If deemed necessary by the department or a local health officer for a particular communicable disease, all persons except the local health officer, his or her representative, attending physicians and nurses, members of the clergy, the members of the immediate family and any other person having a special written permit from the local health officer are forbidden to be in direct contact with the patient.

**252.06(4)(b)** If [s. 250.042 \(1\)](#) applies, all of the following apply:

**252.06(4)(b) 1** No person, other than a person authorized by the public health authority or agent of the public health authority, may enter isolation or quarantine premises.

**252.06(4)(b)2** A violation of [subd. 1.](#) is subject to a fine not to exceed \$10,000 or imprisonment not to exceed 9 months, or both.

**252.06(4)(b) 3** Any person, whether authorized under [subd. 1.](#) or not, who enters an isolation or quarantine premises may be subject to isolation or quarantine under this section.

**252.06(5)** The local health officer shall employ as many persons as are necessary to execute his or her orders and properly guard any place if quarantine or other restrictions on communicable disease are violated or intent to violate is manifested. These persons shall be sworn in as quarantine guards, shall have police powers, and may use all necessary means to enforce the state laws for the prevention and control of communicable diseases, or the orders and rules of the department or any local health officer.

## Wisconsin Public Health Emergency Plan

**252.06(6)(a)** When the local health officer deems it necessary that a person be quarantined or otherwise restricted in a separate place, the officer shall remove the person, if it can be done without danger to the person's health, to this place.

**252.06(6)(b)** When a person confined in a jail, state prison, mental health institute or other public place of detention has a disease which the local health officer or the director of health at the institution deems dangerous to the health of other residents or the neighborhood, the local health officer or the director of health at the institution shall order in writing the removal of the person to a hospital or other place of safety, there to be provided for and securely kept. Upon recovery the person shall be returned; and if the person was committed by a court or under process the removal order or a copy shall be returned by the local health officer to the committing court officer.

**252.06(10)(a)** Expenses for necessary medical care, food and other articles needed for the care of the infected person shall be charged against the person or whoever is liable for the person's support.

**252.06(10)(b)** The county or municipality in which a person with a communicable disease resides is liable for the following costs accruing under this section, unless the costs are payable through 3rd-party liability or through any benefit system:

**252.06(10)(b) 1** The expense of employing guards under sub. (5).

**252.06(10)(b) 2** The expense of maintaining quarantine and enforcing isolation of the quarantined area.

**252.06(10)(b) 3** The expense of conducting examinations and tests for disease carriers made under the direction of the local health officer.

**252.06(10)(b) 4** The expense of care provided under par. (a) to any dependent person, as defined in s. 49.01

### Related Statutes

#### **250.042 Powers and duties of the department as public health authority**

**250.042(1)** If the governor declares a state of emergency related to public health under s. 166.03 (1) (b) 1. and designates the department as the lead state agency to respond to that emergency, the department shall act as the public health authority during the period of the state of emergency. During the period of the state of emergency, the secretary may designate a LPHD as an agent of the department and confer upon the LPHD, acting under that agency, the powers and duties of the public health authority.

#### **252.03 Duties of Local Health Officers**

**252.03(2)** Local health officers may do what is reasonable and necessary for the prevention and suppression of disease; may forbid public gatherings when deemed necessary to control outbreaks or epidemics and shall advise the department of measures taken. **252.03(3)** If the local authorities fail to enforce the communicable disease statutes and rules, the department shall take charge and the county or municipality shall pay expenses thus incurred.

**252.03(4)** No person may interfere with the investigation under this chapter of any place or its occupants by local health officers or their assistants.

#### **252.041(1)(a) Compulsory vaccination during a state of emergency**

**252.041(1)(b)** Isolate or quarantine, under s. 252.06, any individual who is unable or unwilling for reasons specified under sub. (1) to receive vaccination under par. (a).

#### **252.25 Violation of law relating to health**

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**252.25** Any person who willfully violates or obstructs the execution of any state statute or rule, county, city or village ordinance or departmental order under this chapter and relating to the public health, for which no other penalty is prescribed, shall be imprisoned for not more than 30 days or fined not more than \$500 or both.

### **292.01(5) Chemical Disposal of Waste**

**292.01(5)** covers the definition of hazardous substance that also includes chemical substances. In addition Chapter NR 706, Wisconsin Administrative Code, Hazardous Substance Discharge Notification Requirements, identifies when and what hazardous substance discharges need to be reported to the Department of Natural Resources (DNR). Existing Federal and State reporting and disposal regulations must be followed as incidents unfold.

59.34	Coroner, Medical Examiner Duties
69.18	Death Records
157.055 (2)	Disposal of human remains during state of emergency relating to public health
979.01	Reporting deaths required; penalty; taking specimens by coroner or medical examiner
979.10	Cremation

### **2004 Wisconsin ACT 186**

**To renumber** 250.07; **to amend** 20.465 (3) e, 166.03 (2) (a) 1., 2, 3, 166.03 (5) (a), 166.03 (10) and 250.042 (1); and **to create** 15.197 (13), 20.435 (1) (c), 66.0312, 66.03125, 66.0314, 166.02 (6m) and (6r), 250.07 (1m) and 252.06 (10) (c) of the statutes; **relating to:** creating a public health council, reimbursement for quarantine costs, intrastate mutual aid, requiring use of the incident command system in an emergency, exemption from liability during a state of emergency, and making appropriations.

### **Federal Privacy Rule (HIPAA) and Public Health**

*The Health Insurance Portability and Accountability Act of 1996, (HIPAA) privacy rule establishes national standards for the use and management of protected health information (PHI). This policy has thus proven to be of specific interest to public health preparedness planners. The April 11, 2004 issue of CDC's Morbidity and Mortality Weekly Report (MMWR) serves as formal guidance from the Department of Health and Human Services on the implementation and application of the HIPAA Privacy Rule.*

*The HIPAA Privacy Rule is written both to protect an individual citizen's privacy and the effective function of the public health system in order to “**accomplish essential public health objectives and to meet certain other societal needs (e.g., administration of justice and law enforcement).**” \* Selected provisions and definitions of HIPAA specific to public health activities follow:*

*\*Emphasis added.*

#### Protected Health Information

*PHI is defined in an April 11 issue of the CDC's Morbidity and Mortality Weekly Report (MMWR) as*

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“generally individually identifiable health information that is transmitted by, or maintained in, electronic media or any other form or medium. This information must relate to

- 1) the past, present or future physical or mental health, or condition of an individual;
- 2) provision of health care to an individual; or
- 3) payment for the provision of health care to an individual

If the information identifies or provides a reasonable basis to believe it can be used to identify an individual, it is considered individually identifiable health information.”

### Public Health Authority, Defined under HIPAA

*Per the same MMWR*, “A public health authority is broadly defined as including agencies or authorities of the United States, territories, political subdivisions of states or territories, American Indian tribes, or an individual or entity acting under a grant of authority from such agencies and responsible for public health matters as part of an official mandate.”

### Covered Entity, Defined under HIPAA

Covered entities are those that are required to conform with HIPAA rule when handling protected health information (PHI). Entities include health plans, health care clearinghouses, health care providers. The MMWR of April 11, 2004 acknowledges that some public health agencies may perform covered functions such as providing health care and may be subject to the privacy rule for those covered activities. Per the MMWR, such agencies may wish to designate themselves hybrid agencies, thus “*a public health authority can carve out its noncovered functions, so that the majority of Privacy Rule provisions apply only to its health-care component...*”

### Public Health Activities under Memoranda or Agreement

*The HIPAA Privacy Rule provides that the* “other entities” identified in contracts, letters and memoranda of agreement that frequently used by public health “are public health authorities under the Privacy Rule with respect to the activities they conduct under a grant of authority from such a public health agency.”

### Permitted PHI Disclosures without Authorization

*Per the MMWR*, “The Privacy Rule permits covered entities to disclose PHI, without authorization, to public health authorities or other entities who are legally authorized to receive such reports for the purpose of preventing or controlling disease, injury, or disability.” *Further, the MMWR states that* “PHI can be disclosed to public health authorities and their authorized agents for public health purposes including but not limited to public health surveillance, investigations, and interventions.”

### Minimum Necessary Standard

*With regard to the amount of information that may be disclosed to a public health or other non-covered entity, the MMWR states that* “The Privacy Rule usually directs covered entities to limit the amount of information disclosed to the minimum necessary to achieve the specific goal [45 CFR s. 164.514(d)(1)]. This requirement usually applies to disclosures to a public health agency. It would

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not apply, however, if the disclosure were required by law, authorized by the individual, or for treatment purposes.\* A covered entity may also reasonably rely on a public official's determination that the information requested is the minimum necessary for public health purposes."

\*Emphasis added.

### The HIPAA Privacy Rule and State Laws

According to the MMWR the Privacy Rule preempts less stringent state laws that related to privacy of PHI. Further, according to the MMWR, the Department of Health and Human Services "may, upon specific request from a state or other entity or person, determine that a provision of state law that is contrary to the federal requirements and that meets certain additional criteria, will not be preempted by the federal requirements." *The MMWR identifies several possible reasons for such a determination, including that the state law "is necessary to serve a compelling public health, safety or welfare need and, if a Privacy Rule provision is at issue, if the Secretary determines that the intrusion into privacy is warranted when balanced against the need to be served."* Finally, the MMWR notes that the Privacy Rule "specifically does not preempt contrary state public health laws that provide for the reporting of disease or injury, child abuse, birth or death, or for the conduct of public health surveillance, investigation or intervention [45 CFR s. 160.202]."\*

\*Emphasis added.



**PART F**  
**GLOSSARY**

<b>Term</b>	<b>Definition</b>
<b>2-1-1- Wisconsin</b>	A local and statewide telephone communications networks for disseminating public health information.
<b>ACIP</b>	Advisory Committee on Immunization Practices (for CDC)
<b>AII</b>	Airborne Infection Isolation
<b>AII Room</b>	An inpatient room in any functional area of the hospital that is engineered to provide a negative pressure atmosphere in that room.
<b>All-Hazard</b>	Covering all possible hazards whether natural, accidental, negligent, or intentional
<b>Anthrax</b>	A non-contagious potentially fatal disease caused by breathing, eating, or skin contact with spores of the skin bacteria known as <i>Bacillus anthracis</i> .
<b>APIC</b>	Association of Professionals in Infection Control and Epidemiology
<b>Appendix</b>	For the purpose of this PHEP an appendix is a reference to a related or supporting plan maintained by another organization.
<b>Attachment</b>	For the purpose of this PHEP an attachment is a document, table, diagram or chart that supports the plan section where it is identified.
<b>Biological Agent</b>	Living organisms, the materials derived from them that cause disease in, or harm humans, animals, plants, or cause deterioration of material. Biological agents may be found a liquid droplets, aerosols, or dry powders. A biological agent can be adapted and used as a terrorist weapon, such as anthrax, tularemia, cholera, encephalitis, plague, or botulism. There are three different types of biological agents: bacteria, viruses, and toxins.
<b>Biological Attack</b>	The deliberate release of bacteria, viruses, or toxins to produce death or disease in humans, animals, or plants.
<b>Biological Incident</b>	A natural, accidental, negligent, or deliberate exposure involving a biological agent.

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<b>Term</b>	<b>Definition</b>
<b>Bio-Safety Level</b>	<p>A system for classifying laboratory safety practices, in four levels according to degree of protection provided to personnel, the environment, and the community for laboratories dealing with infectious microorganisms.</p> <ul style="list-style-type: none"> <li>• BSL1 – suitable for work involving well characterized agents not known to consistently cause disease in health adult humans, and of minimal potential hazard to laboratory personnel and the environment.</li> <li>• BSL 2 – similar to BSL 1 and is suitable for work involving agents of moderate potential hazard to personnel and the environment</li> <li>• BSL 3 – applicable to clinical, diagnostic, teaching, research, or production facilities in which work is done with indigenous or exotic agents which may cause serious or potentially lethal disease as a result of exposure by the inhalation route.</li> <li>• BSL 4 – required for work with dangerous and exotic agents that pose a high individual risk of aerosol-transmitted laboratory infections and life-threatening disease.</li> </ul>
<b>Bioterrorism</b>	The use of a biological agent in a terrorist incident, the intentional use of microorganism(s) or toxin(s) to produce death or disease in humans, animals, or plants.
<b>BOIDDOOPHTE</b>	Bioterrorism, Other Infectious Disease Outbreaks and Other Public Health Threats and Emergencies
<b>BQA</b>	Bureau of Quality Assurance
<b>Category-A Agents</b>	The biological terrorism agents having the greatest potential for adverse public health impact with mass casualties.
<b>Category-A Diseases</b>	The Category-A diseases are smallpox; anthrax; plague; botulism; tularemia and viral hemorrhagic fevers (e.g. Ebola and Lassa viruses).
<b>Category-B Agents</b>	The biological terrorism agents that are more readily available, may not necessarily cause mass casualties, and their use may be found more often in the settings of biological crime or extortion than terrorism.
<b>Category-C Agents</b>	Emerging infectious diseases or agents with characteristics that could be exploited for deliberate dissemination.
<b>CDC</b>	Centers for Disease Control and Prevention (agency of HHS)
<b>CERT</b>	Community Emergency Response Team
<b>Characterization</b>	Identification of the strain of an influenza virus such as A/Panama.

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<b>Term</b>	<b>Definition</b>
<b>Chemical Warfare Agent</b>	A chemical substance (such as a nerve agent, blister agent, blood agent, choking agent, or irritating agent) used to kill, seriously injure, or incapacitate people through its physiological effects.
<b>Clinical Labs</b>	<p>Reference Laboratories, referred to under Laboratory Levels as “Level B” and “Level C” laboratories, which provide confirmatory testing for the agents of bioterrorism. Reference Laboratories are usually public health laboratories that have BSL-3 capabilities, can confirm the identification of bioterrorism agents using conventional and molecular methods, and have rapid methods capability.</p> <p>The Wisconsin State Laboratory of Hygiene (WSLH) serves as the coordinating laboratory of the Wisconsin Laboratory Response Network (WLRN). The City of Milwaukee Health Department Bureau of Laboratories and Marshfield Clinical Research Foundation Laboratory also serve as Reference Laboratories for bioterrorism. The WSLH serves as Wisconsin’s only Reference Laboratory for chemical terrorism response.</p>
<b>CMEO</b>	Coroner/Medical Examiner
<b>CMFMP</b>	County Mass Fatality Mortuary Plan
<b>COBRA</b>	Consolidated Omnibus Budget Reconciliation Act
<b>Cohorts</b>	A group of people united in an effort or difficulty.
<b>Communicable Disease</b>	An illness due to a specific infectious agent or to toxic products that arises through transmission of that agent or its products from an infected person or animal to a susceptible host.
<b>Communications</b>	The system by which the message is communicated.
<b>Crisis Communication</b>	Exchange of information concerning the existence, nature, form, severity, or acceptability of health or environmental risks.
<b>DATCP</b>	Department of Agriculture Trade and Consumer Protection
<b>DCFS</b>	Division of Children and Family Services
<b>Decontamination</b>	The process of making people, objects, or areas safe by absorbing, destroying, neutralizing, making harmless, or removing chemical, biological, or radiological material
<b>DHFS</b>	Department of Health and Family Services

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<b>Term</b>	<b>Definition</b>
<b>Disaster, major (federal)</b>	“Major disaster” means any natural catastrophe (including any hurricane, tornado, storm, high water, wind driven water, tidal wave, tsunami, earthquake, volcanic eruption, landslide, mudslide, snowstorm, or drought) or regardless of cause, any fire, flood, or explosion, in any part of the United States, which in the determination of the President, causes damage of sufficient severity and magnitude to warrant major disaster assistance under the Stafford Act.
<b>DMAT</b>	Disaster Medical Assistance Team
<b>DMORT</b>	Disaster Mortuary Operational Response Team - A coordinated effort of forensic experts and mortuary personnel to effectively handle a mass fatality disaster
<b>DOA</b>	Department of Administration
<b>DPH</b>	Division of Public Health
<b>DPI</b>	Department of Public Instruction
<b>Drills</b>	Small-scale, internally conducted, activities aimed at providing a more “hands-on” teaching environment to familiarize staff with the actual procedures necessary for emergency operations.
<b>Emergency</b>	A natural or manmade event that suddenly disrupts the provision of essential public services; disrupts care and treatment; or changes or increases demands for an organization’s resources.
<b>EMS</b>	Emergency Medical Service - Private or community operated companies or squads that provide prompt response medical assistance at the location of the emergency. Also looked to for transport of victims to a fixed medical facility.
<b>EMT</b>	Emergency Medical Technician - A practitioner credentialed by a State to function as an EMT by a State Emergency Medical (EMS) system.
<b>Endemic</b>	A disease that is continually present in a community or a region.
<b>EOC</b>	Emergency Operating Center - A facility (permanent or temporary) in the local community that is used by responders to gather, coordinate, communicate and make decisions for the health and well being of the community they are serving during times of natural or man-made disaster.
<b>EOP</b>	Emergency Operations Plan
<b>EPA</b>	Environmental Protection Agency (US)
<b>Epidemic</b>	The occurrence of more cases of disease than expected in a given area or among a specific group of people during a particular period of time.

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<b>Term</b>	<b>Definition</b>
<b>Event</b>	An occurrence involving biological or infectious disease agents that is caused by a criminal act or natural occurrence requiring a response greater than that seen during a normal day's activity.
<b>Exercise</b>	A test to enhance the overall capability of a community or organization based on plans, policies, and procedures. Preparation and practice of the responsibilities for response and recovery from emergencies or disasters that will enhance the ability to protect lives, property, and the environment. Exercises identify areas that are proficient and those that require improvement.
<b>FDA</b>	Food and Drug Administration (agency of HHS)
<b>Febrile</b>	Denoting or relating to fever.
<b>FIRST</b>	Fatality Incident Response Support Team (formerly – Disaster Assistance Response Teams)
<b>First Responder</b>	Those individuals who, in the early stages of an incident are responsible for the protection and preservation of life, property, evidence, and the environment
<b>HAN</b>	Health Alert Network - An Internet based program used to communicate health and emergency messages
<b>Hazard</b>	A source of potential harm from past, current, or future exposures
<b>HazMat</b>	Hazardous Materials - Any material that is explosive, flammable, poisonous, corrosive, reactive, or radioactive, or any combinations thereof, and requires special care in handling because of the hazard it poses to public health, safety, or the environment.
<b>HEICS</b>	Hospital Emergency Incident Command System – An emergency management system that employs a logical management structure, defined responsibilities, clear reporting channels, and common nomenclature to help unify hospitals with other emergency responders.
<b>HEPP</b>	The State of Wisconsin Hospital Emergency Preparedness Plan
<b>HHS</b>	Department of Health and Human Services (Federal)
<b>High-Hazard Area</b>	Geographic location that for planning purposes has been determined through historical experience and vulnerability analysis to be likely to experience the effects of a specific hazard (e.g. hurricane, earthquake, hazardous materials accident, etc.) resulting in vast property damage or loss of life.
<b>HIPAA</b>	Health Insurance Portability and Accountability Act

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<b>Term</b>	<b>Definition</b>
<b>HRSA</b>	Health Resources and Services Administration - An agency of the U.S. Department of Health and Human Services; HRSA assures the availability of quality health care to low income, uninsured, isolated, vulnerable and special needs populations and meets their unique health care needs.
<b>ICP</b>	Infection Control Practitioner
<b>ICS</b>	Incident Command System – The direction and control scheme used by first response and other agencies to manage emergencies
<b>ILI</b>	Influenza-like Illness – The presence of fever >100d. Fahrenheit (37.78 degrees Celsius), with a cough or sore throat.
<b>Incident</b>	A slow or fast developing mass casualty situation, which may be caused by any of a number of initiators such as an act of bioterrorism, a naturally occurring infectious disease outbreak or any circumstance that could produce a large number of casualties.
<b>JIC</b>	Joint Information Center - A pre-determined location at which the Public Information Officers (PIO) from the organizations represented in an activated Emergency Operations Center (EOC) can gather to develop and verify information that need to be transmitted to the public using both broadcast and print media.
<b>JPIC</b>	Joint Public Information Center - A central location for involved agencies to coordinate public information activities and a forum for news media representatives to receive disaster or emergency information
<b>Laboratory Levels</b>	<p>A system for classifying CDC, Department of Defense, Federal Bureau of Investigation (FBI), and US Army Medical Research Institute of Infectious Diseases laboratories by their capabilities. Classification levels are:</p> <ul style="list-style-type: none"> <li>• A – routine clinical testing, Includes independent clinical labs and those at universities and community hospitals.</li> <li>• B – More specialized capabilities. Includes many state and local public health laboratories.</li> <li>• C – More sophisticated public health labs and reference labs such as those run by CDC.</li> <li>• D – Possessing sophisticated containment equipment and expertise to deal with the most dangerous, virulent pathogens.</li> </ul>
<b>LIN</b>	Laboratory Information Network
<b>LPHD</b>	Local Public Health Department
<b>MHDOHL</b>	(City of) Milwaukee Health Department Public Health Laboratory

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<b>Term</b>	<b>Definition</b>
<b>MMRS</b>	Metropolitan Medical Response System – A program intended to increase cities’ ability to respond to a terrorist attack by coordinating the efforts of local law enforcement, fire, HazMat, EMS, hospital, public health, and other personnel.
<b>N95</b>	Filtering characteristic of an effective mask, resistant to aerosol hazards.
<b>NEDSS</b>	National Electronic Disease Surveillance System – a CDC initiative promoting the use of data and information system standards to improve disease surveillance systems at federal, state, and local levels.
<b>NIMS</b>	National Incident Management System – the single all-hazard incident management system required by Department of Homeland Security (DHS) Presidential Directive 5 that will govern the management of the National Response Plan. NIMS will replace the National Inter-Agency Incident Management System.
<b>Novel virus</b>	A virus rarely or not previously known to infect humans.
<b>NPAir</b>	Negative Pressure Air Room - An inpatient room in any functional area of the hospital that is engineered to provide a negative pressure atmosphere in relation to the corridor and surrounding areas with exhaust externally vented away from air intakes or where people may pass.
<b>NREVSS</b>	National Respiratory and Enteric Virus Surveillance System
<b>Outbreak</b>	Same as epidemic. The occurrence of more cases of disease than expected in a given area or among a specific group of people during a particular period of time.
<b>Pandemic</b>	The occurrence of a disease in excess of normal expectations in extensive regions, countries, or continents.
<b>PHEP</b>	(State of Wisconsin ) Public Health Emergency Plan
<b>PIO</b>	Public Information Officer
<b>PPE</b>	Personal Protective Equipment – Equipment and clothing required to shield or isolate personnel from the chemical, physical, thermal, or biological hazards that may be encountered at a hazardous materials incident.
<b>Preparedness</b>	Refers to the existence of plans, procedures, policies, training, and equipment necessary at the federal, state, and local levels to maximize the ability to prevent, respond to, and recover from major events. “Readiness” is used interchangeably with “Preparedness.”

## Wisconsin Public Health Emergency Plan

<b>Term</b>	<b>Definition</b>
<b>Public Health</b>	Organized efforts of society to protect, promote, and restore peoples' health. It is the combination of science, skill, and beliefs that is directed to the maintenance and improvement of the health of all the people through collective or social actions.
<b>Public Health Emergency</b>	Occurrence or imminent threat of exposure to an extremely dangerous condition or a highly infectious or toxic agent, including a communicable disease, that poses an imminent threat of substantial harm to the population, or any portion thereof. In general, a public health emergency is one that requires a population-based approach.
<b>Push Package</b>	A large shipment of medical supplies and pharmaceuticals sent from the Strategic National Stockpile to a state undergoing an emergency within 12 hours of federal approval of a request by the states' Governor.
<b>Quarantine</b>	Precautionary physical separation of persons who have or may have been exposed to a threatening communicable disease or a potentially threatening communicable disease and who do not show signs or symptoms of a threatening communicable disease from non-quarantined persons.
<b>Radiation</b>	High-energy particle or gamma ray that is emitted by an atom as the substance undergoes radioactive decay. These can be either charged alpha or beta particles or neutral neutron or gamma rays.
<b>Radiological Material</b>	Any material that spontaneously emits ionizing radiation.
<b>Release</b>	Any spilling, leaking, pumping, pouring, emitting, emptying, discharging, injecting, escaping, leaching, dumping, or disposing into the environment (including the abandonment or discharging of barrels, containers, or other closed receptacles containing any hazardous substance, pollutant, or contaminant).
<b>Resource</b>	Any data, information, or equipment that may need to be accessed or obtained during the course of an incident.
<b>Responders</b>	Those individuals who, in all stages of an incident, are responsible for the protection and preservation of life, property, evidence, and the environment.
<b>Response</b>	Activities to address the immediate and short-term effects of an emergency or disaster. Response includes immediate actions to save lives, protect property, and meet basic human needs as well as executing the plan and resources created to preserve life, protect property, or provide services.
<b>Risk</b>	A measure of the harm to human health that results from exposure; uncertainty that surrounds future events and their outcome.



## Wisconsin Public Health Emergency Plan

<b>Term</b>	<b>Definition</b>
<b>RSS</b>	Receiving, Staging, and Storing warehouses for receipt of the Strategic National Stockpile (SNS).
<b>SARS</b>	Severe Acute Respiratory Syndrome
<b>Sentinel Labs</b>	<p>Sentinel Laboratories, referred to under Laboratory Levels as “Level A” laboratories, are clinical laboratories that perform microbiology and operate at Bio-Safety Level 2 (BSL-2), but would adopt Bio-Safety Level 3 (BSL-3) practices when working with a suspected bioterrorism agent. Any clinical laboratories that perform bacteriology and are Clinical Laboratory Improvement Amendments (CLIA) certified may be Sentinel Laboratories, with no formal registration required.</p> <p>The role of Sentinel Laboratories is to recognize the agents of bioterrorism, perform testing to rule out the agents of bioterrorism, and refer suspect isolates to Reference Laboratories.</p> <p>In Wisconsin, Sentinel Laboratories are comprised of hospital-based and large clinical laboratories that perform microbiology; the use of a Biological Safety Cabinet (BSC) and bio-safety Level 2 criteria have not been strictly applied for inclusion in the Wisconsin Laboratory Response Network.</p>
<b>Smallpox</b>	Variola, a virus that causes a serious, contagious, and sometimes fatal disease, producing substantial morbidity and mortality. There is no specific treatment for smallpox and the only prevention is vaccination.
<b>SNS</b>	Strategic National Stockpile - A federal cache of medical supplies and equipment to be used in emergency and disaster situations
<b>Special Populations</b>	Any individual, group, or community, who’s physical, mental, emotional, cognitive, cultural, ethnic, socio-economic status, age, language or other circumstance, creates barriers understanding and/or the ability to manage the effects of disaster in the manner in which the general population has been requested to proceed.
<b>Stakeholder</b>	And individual, group, or organization that may be affected by or otherwise interested in a risk management decision.
<b>Subtype</b>	Identification of influenza A viruses according to the hemagglutinin (H) and neuraminidase (N) components of the virus, such as H1N1 or H3N2.
<b>Surge Capacity</b>	The accommodation by the health system to a transient sudden rise in demand for health care following an incident with real or perceived adverse health effects.
<b>Surveillance</b>	The collection, analysis and dissemination of data
<b>Sustainability</b>	Ability to continue response operations for the prescribed duration necessary.

## Wisconsin Public Health Emergency Plan

<b>Term</b>	<b>Definition</b>
<b>Syndromic</b>	Based on clinical signs and symptoms
<b>Terrorism</b>	The unlawful use of force or violence against persons or property to intimidate or coerce a government, the civilian population, or any segment thereof, in furtherance of political or social objectives.
<b>Threatening Communicable Disease</b>	The term used in relation to the reporting of communicable diseases in the Public Health Act and defined in the Public Health Emergency Response Act. This term means a disease that causes death or threat that passes from one person to another and for which there is no means by which the public can reasonably avoid the risk of contracting the disease. The term does not include infection with the human immunodeficiency virus (HIV), acquired immune deficiency syndrome (AIDS), or other infections attributable to infection with HIV.
<b>Triage Tag</b>	A multi purpose tag that is used by emergency medical or field medical personnel when documenting the medical condition and treatment category of event victims in the field.
<b>Vaccination</b>	The injection or inoculation of a vaccine for the purpose of inducing active immunity
<b>VAERS</b>	Vaccine Adverse Events Reporting System
<b>Virus</b>	The simplest types of microorganisms, lacking a system for their own metabolism. They depend on living cells to multiply and cannot live outside of a host. Types of viruses include smallpox, Ebola, Marburg, and Lassa fever.
<b>VIS</b>	Vaccine Information Statement
<b>WLRN</b>	Wisconsin Laboratory Response Network
<b>WMD</b>	<p>Weapons of Mass Destruction :</p> <ul style="list-style-type: none"> <li>Any “destructive device” defined as any explosive, incendiary, or poison gas, bomb, grenade, or rocket having a propellant charge of more than 4 ounces, missile having an explosive or incendiary charge of more than ¼ ounce.</li> <li>Any device, material, or substance used with intent to cause death or serious injury to persons or significant damage to property.</li> </ul>
<b>WEAVR</b>	Wisconsin Emergency Assistance Volunteer Registry
<b>WEM</b>	Wisconsin Emergency Management
<b>WHO</b>	World Health Organization
<b>WIR</b>	Wisconsin Immunization Registry

## Wisconsin Public Health Emergency Plan

<b>Term</b>	<b>Definition</b>
<b>WMD Chem/Bio</b>	Shorthand phrase for “Weapons of Mass Destruction, Chemical/Biological,” in reference to those substances that were developed by military institutions to create widespread injury, illness, or death.
<b>WSLH</b>	Wisconsin State Laboratory of Hygiene
<b>Zone, Contamination Reduction (Warm Zone)</b>	The area between the Exclusion Zone and the Support Zone. This zone contains the personnel decontamination station. This zone may require a lesser degree of personnel protection than in the Exclusion Zone. This separates the contaminated area from the clean area and acts as a buffer to reduce contamination of the “clean” area.
<b>Zone, Exclusion (Hot Zone)</b>	The area immediately around a spill or release and where contamination does or could occur. Special protection is required for all personnel while in this zone.
<b>Zone, Support (Cold Zone)</b>	The “clean” area outside of the contamination control line. In this area, equipment and personnel are not expected to become contaminated. Special protective clothing is not required. This is the area where resources are assembled to support the hazardous substances/materials release operation